CHAPTER I

BACKGROUND

The lack of affordable and medically appropriate housing for persons living with HIV/AIDS and their families is an ongoing concern for AIDS housing providers, policymakers, and advocates across the country. Stable housing promotes improved health status, sobriety or decreased use of nonprescription drugs, and a return for some persons with AIDS to productive work and social activities. Stable housing is the cornerstone of HIV/AIDS treatment- U.S. Department of Housing and Urban Development.

The District of Columbia Department of Health HIV/AIDS Administration is at the center of District agencies committed to providing appropriate housing and other support services to persons living with HIV/AIDS (PLWHA). In order that it may provide a more efficient and effective service that is data driven and with a long-term perspective, the D.C. Department of Health HIV/AIDS Administration awarded a grant (No. 0214-03-HAA) to the Howard University Center for Urban Progress (CUP) in October 2004 to study and report on the following:

1. An analysis of issues that influence housing availability; the availability and demand for housing by persons living with HIV/AIDS in the District; the housing gap and the measures in place to narrow this gap.
2. A comprehensive plan for monitoring and evaluation of the programs funded under Housing Opportunities for Persons with HIV/AIDS (HOPWA) taking into account the theoretical and practical issues affecting monitoring and evaluation of housing programs; and to recommend a monitoring and evaluation plan for the HIV/AIDS Administration.
3. Conduct a survey of housing providers funded under the HOPWA program by HIV/AIDS Administration and make recommendations to make the program implementation more effective.
4. Prepare a housing strategic plan for the consideration of the HIV/AIDS Administration.

This report is the outcome of the study conducted by CUP over the grant period. The report, besides covering a wide range of issues is also timely as it is being prepared and shared with the stakeholders against a backdrop of a rapidly transforming HIV/AIDS scenario in the District. In this report we present a detailed analysis of factors that affect, and in turn are affected by, the demand for and supply of housing for persons living with Human Immunodeficiency Virus (HIV) and/or Acquired Immunodeficiency Syndrome (AIDS) with particular reference to the prevailing conditions in the District of Columbia (D.C.). The main objective of this report is to take stock of current housing situations and incorporate lessons learnt, so that policy makers may make informed decisions on how best to turn today’s policies, programs and available funds to the benefit of the neediest and those most affected by the epidemic. To understand where we are and where we wish to go, we must also be clear where we come from. This report opens with an overview of federal legislations directed toward the homeless and affordable housing, including the
U.S. Department of Housing and Urban Development sponsored HOPWA program. It goes on to present the HIV/AIDS epidemiology in the District and the present state of housing in D.C. with particular reference to housing for persons living with HIV/AIDS and identifies the housing gap. The final three chapters present an analysis of the housing service provider survey results, a monitoring and evaluation plan, and a four-year strategic plan for improving housing services for persons living with HIV/AIDS respectively. The strategic plan identifies goals and objectives and provides eight strategic directions to achieve these goals.

The District of Columbia has the highest rate of AIDS cases in the country. As of December 2002, 15,132 cumulative AIDS cases have been reported in the District. Of the adult/adolescent cases, 20 percent are females and 80 percent are males. Blacks comprise 75 percent of AIDS cases. In 2002, the rate of reported AIDS cases in the District was 162.4 per 100,000 population as compared to 14.8 per 100,000 for the country as a whole. The Human Immunodeficiency Virus epidemic continues to grow and evolve over time. In contrast to the early eighties (when the disease was first identified) and when males, gays, and Caucasians were thought to be the main victims, HIV/AIDS cases today are being increasingly diagnosed in blacks, heterosexuals, seniors and women. For instance, in the District of Columbia, females accounted for 29 percent of the AIDS cases in 1998-2002 as against 16 percent in the period 1990-1995. Similarly, HIV/AIDS cases among those aged fifty and above are also increasing at a rate higher than that of the national average. In the period 1990-1995, men who have sex with men (MSM) was the predominant mode of HIV transmission (63 percent) followed by injection drug use (24 percent) and heterosexual contact (5 percent). However, during the period 1998-2002, the mode of HIV transmission changed dramatically: HIV transmission due to MSM was 32 percent, followed by injection drug use (24 percent) and heterosexual contact (24 percent).

The complexity of issues facing persons living with HIV/AIDS has continued to grow as the epidemic affects an increasing number of people from marginalized backgrounds – the poor and homeless, the uninsured, immigrants, and the undocumented. As is well known, economic, social, and health related issues affect low-income groups disproportionately. “Research consistently indicates that life circumstances associated with low socioeconomic status, gender, race and ethnic disadvantage and other high-risk circumstances are strongly associated with a wide range of poor health outcomes. Policies that take account of and enhance positive health outcomes among subgroups at high risk of poor health outcomes need to be designed and implemented.”

A large number of persons living with HIV/AIDS today are increasingly battling with not only the disease but also with the issues of poverty, homelessness, unemployment, mental health, and other conditions that affect their wellbeing almost on a daily basis. According to the latest available data, 23 percent of the D.C. residents live in poverty and the per

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capita income is $28,659. According to the U.S. Census Bureau\(^2\), in the District of Columbia, out of the total households of 245,785, 60,175 (24.4%) households have extremely low income (0-30% of median income); 33,246 (13.5%) households have very low income (30 – 50% of median Income); 31,153 (12.6%) households have low income (50-80% of median income); and 121,211 (49.5%) households have moderate to high income (80%+ of the median income).

Homelessness is a major issue affecting low-income groups in the District. In 2002 and 2003 an estimated 16,000 to 17,500 people in the District of Columbia were homeless at some point during the year and as many as 2,000 of these were ‘chronically homeless’- persons who lived either in shelters or on the streets throughout the year.\(^3\) At the last point-in-time enumeration undertaken in January 2004 by the Metropolitan Washington Council of Governments, about 8,250 persons were within the D.C. homeless continuum of care. About 6,100 of these persons were on the streets, in shelters or in transitional facilities. According to a recent study by the National Low Income Housing Coalition on the question of housing affordability, in the District of Columbia, a low-income household (earning $25,440 or 30% of the Area Median Income of $84,800) can afford monthly rent of no more $636, while the HUD determined Fair Market Rent (FMR) for a two bedroom unit is $1,218, for a one bedroom unit is $1,039 and no bedroom unit is $913.\(^4\)

Chronic homelessness is an issue for many communities and subpopulations in the country today. However, reducing homelessness and achieving stable housing for people living with HIV/AIDS assumes special significance and priority. Studies have shown that in the absence of stable housing, PLWHA are unable to receive adequate health care and/or adhere to the strict regimen that AIDS treatment calls for. In order to increase housing opportunities for persons living with HIV/AIDS in a targeted manner, the government created the Housing Opportunities for People with AIDS program in 1992.

The Housing Opportunities for Persons with HIV/AIDS program was created through the National Affordable Housing Act of 1990, as amended by the Housing and Community Development Act of 1992. HOPWA is administered by the Office of HIV/AIDS Housing at the U.S. Department of Housing and Urban Development (HUD) headquarters. It is a federally administered program that funds states and local governments to develop strategies for meeting the housing and other supportive service needs of persons living with HIV/AIDS and their families. The goals and objectives of HOPWA are to: (1) meet HUD’s national goal of increasing the availability of decent, safe, and affordable housing for low-income people living with HIV/AIDS; (2) create and support affordable housing units for people living with HIV/AIDS by matching HOPWA funds with other resources through community planning for comprehensive housing strategies; and, (3) create

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partnerships and innovative strategies among state and local governments and community-based nonprofit organizations to identify and serve the housing and supportive service needs of people living with HIV/AIDS5.

Local HOPWA funds are directed towards assisting eligible clients with housing designed to prevent homelessness, including emergency short-term rental, mortgage and utility assistance, long-term rental assistance, project-based rental assistance, operating assistance for project-based housing and community residences; HOPWA funds also are directed towards housing information, referral and advocacy services.

Apart from HOPWA, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act also provides targeted assistance to PLWHA. The Ryan White CARE program is authorized by a federal legislation that addresses the unmet health needs of persons living with HIV disease by funding primary health care and support services that enhance access to and retention in care. The CARE Act works toward these goals by funding local and state programs that provide primary medical care and support services; healthcare provider training; and technical assistance to help funded programs address implementation and emerging HIV care issues. Titles I, II and IV of the Ryan White CARE Act allow housing-related assistance as eligible expenditures.

While health care and housing are critical to the care of PLWHA, there are other complex economic, social and psychological challenges to their wellbeing that they face. In many communities, PLWHA continue to experience social isolation and discrimination. The complexities of the disease in many cases incorporate drug and alcohol dependency issues and mental illness. Low-income, poverty, housing difficulties, challenges to finding and maintaining jobs, establishing and maintaining primary and specialist care relationships, treatment adherence, opportunistic infections, are the many challenges faced by PLWHA.

Additional challenges in the care and support needs of PLWHA in recent years have been brought about by several factors, including:

- changing demographics of people infected with HIV/AIDS;
- development of long-term responses to HIV treatments;
- longer life spans, and the aging of PLWHA;
- growing complexity of mental health impacts of the disease; and,
- pressures of inadequate accommodation and income levels.

Since the clinical and medical situation of PLWHA can fluctuate, their care and support needs to be flexible. Additionally, persons who have been living with HIV/AIDS for longer periods may have needs that are significantly different from

5 U.S. Department of Housing and Urban Development website
the needs of those persons who are newly diagnosed. Services therefore need to be flexible enough to accommodate these changing needs.

In the last decade, blacks, females, and people with chemical dependency issues have been among the fastest growing groups of new HIV infection. Housing people with substance abuse and mental health issues or those previously incarcerated offers special challenges. There are few housing options available for individuals exiting the criminal justice system or for those who have poor or no credit. Undocumented individuals cannot be served by most of the housing programs that receive funding from HUD. Increasingly, new clients are presenting with language and cultural barriers that are proving to be challenge to the AIDS housing and service systems.

Recent studies confirm that persons living with HIV/AIDS must have stable housing to access comprehensive healthcare and adhere to complex HIV/AIDS drug therapies. Stable housing promotes improved health status, sobriety or decreased use of nonprescription drugs, and a return for some persons with AIDS to productive work and social activities. Stable housing is the cornerstone of HIV/AIDS treatment. Even though stable housing has been shown to be a necessary link to medical and supportive services, accessing housing is difficult as the wait for affordable housing has increased in many communities across the country. Compounding the problem of waiting lists is access to housing with the services to care and treat the increasing number of persons living not only with HIV/AIDS but also with histories of homelessness, mental illness, and substance abuse. Without housing, many persons living with AIDS are not able to maintain medical treatment and are at risk of rapidly diminishing health. In the District of Columbia there are about 439 people living with AIDS who are homeless. High housing costs combined with the fact that people with AIDS are living longer as a result of improved medical interventions, tend to put pressure on available housing units.

Homeless individuals with HIV/AIDS depend almost entirely on publicly-funded housing to assist them in attempting to stabilize their living situations and health. This includes federal funds provided through HUD - HOPWA, and rental subsidy vouchers through Section 8 and the McKinney/Homeless Assistance Grants. Some communities also combine federal HOPWA funds with CARE Title I and local general funds to expand the availability of affordable housing.

In the light of the foregoing discussion, some of the areas for priority action by the policy makers in the care of support of PLWHA are:

1. Provide comprehensive services that promote self-sufficiency and independence of PLWHA.

• Ensure that PLWHA can access appropriate housing, treatments, care and support including appropriate income and disability support;
• Develop long-term support for PLWHA who are most at-risk including the aging, youth, the transgendered, and women; and,
• Develop job readiness programs for the neediest, such as people returning from prison system, youth, and other vulnerable sections.

2. Promote effective networks and partnerships among service providers.

• Improve collaborations between mental health, clinical and welfare services to address the care and support needs of PLWHA who are multiply diagnosed;
• Ensure community engagement in policy development, planning and delivery of services to PLWHA; and,
• Develop HIV positive peer support for special subpopulations as youth, women and the aging.

3. Build the organizational and managerial capacities of service providers.

• Provide appropriate training and skills development for staff of HIV/AIDS services;
• Support the HIV/AIDS community sector to improve its capacity to work with people from different backgrounds, races and ethnicities;
• Encourage the sharing of best practices and innovative strategies across jurisdictions to provide different types of services to PLWHA; and,
• Develop culturally effective promotion programs for subpopulations at high risk.

At a time when housing needs are increasing and affordable housing units are diminishing, compounding the problem is the overall decline in government funding in many areas, including HOPWA. Due to increases in rents throughout the District, fewer households are being served through the tenant-based rental assistance (TBRA) program funded by HOPWA. There are long waiting lists for TBRA and even the vouchers issued under TBRA are not fully utilized due to non-availability of suitable housing units, particularly for families. It is expected that the number of persons living with AIDS will continue to increase as treatment options grow, and that there will be a related increase in demand for housing units and housing assistance. Given the funding climate and the commitment of resources necessary to maintain the system that has been developed locally, it may not be possible to significantly expand the existing inventory of affordable housing dedicated to people living with AIDS. Consequently, it is imperative to develop a long-term strategy for meeting the increasing housing needs of PLWHA in the District.

In the final analysis, the success of any attempt to provide health care and support to PLWHA is dependent on a continuous and ongoing assessment of the impact of policies and programs on PLWHA and their families. Equally important is the impact of policies on the affected communities in terms of housing, mental health, welfare, human rights, criminal justice, income support, and employment. At a time when the availability of funds is diminishing, on the one hand, and the need and complexity of services is
growing, on the other, there is a need for both the efficient utilization of resources and their effective and targeted use for subpopulations that are most at-risk. This calls for an effective monitoring and evaluation system by both the grantors and the grantees. Sound monitoring and evaluation plans help insure that scarce public and private resources are being utilized optimally and to assure the public that the management of funded programs by government departments have the desired effects on communities. Monitoring and evaluation mechanisms are also required to ensure that policies and practices are based on the best available evidence. Systematic monitoring and evaluation will ensure that individual programs are part of a larger picture and contribute to the overall objectives and priorities of the state and even the nation. It will also provide an accountability mechanism for use by all concerned parties.

In order to keep pace with the evolving nature of the epidemic and to meet the growing needs of PLWHA and, it is imperative to have long-term strategic plans that clearly spell out the vision, mission, goals and objectives of the service organizations, be it the District of Columbia HIV/AIDS Administration (HAA), and/or the grass roots service providers who mostly are community-based and faith-based organizations entrenched in the communities that they serve. Organizations function most effectively and efficiently when their work is guided by a long-term strategic plan. Strategic plans are essential to ensure that members of the organization are working toward the same goals. Once a strategic plan is carefully conceived and designed with relevance to the organizational mission and goals, the plan becomes the basis for staff and other stakeholder work plans. Such plans are also necessary to assess and adjust the organization’s direction in response to changing environments. Long-term plans serve well the organizations that work in an environment that is constantly changing, that deal with some of the most vulnerable sections of the populations, and those that work under conditions of scarcity of financial resources.

The main purpose of this is to develop a strategic plan for the housing division of the HAA for the years 2006 to 2010. This strategic plan may be found in Chapter VIII. The earlier chapters are, in fact, the precursors to this chapter; they lead us to the final chapter by defining the environment, and looking at the strengths, weaknesses, opportunities and threats that confront organizations that serve PLWHA in one capacity or another. Chapter I presents a snapshot of the issues that influence policies and practices that guide service providers. Chapter II takes an in depth look into the concepts of homelessness, and legislative actions taken to confront this serious problem. The two Acts that specifically target PLWHA, the HOPWA and Ryan White CARE programs are also discussed in detail in this chapter. Chapter III presents the trends in HIV/AIDS epidemiology in D.C. It takes a look at how the epidemic has progressed over the years, its evolution over the years, and how it is affecting different sections of the D.C. population. Chapter IV takes a look at homelessness in D.C. and issues relating to housing affordability. It also takes an in depth look at the present state of housing and the government strategies to reduce homelessness in the District. Chapter V deals with the implementation of the HOPWA program in D.C. in terms of its service delivery channels and accomplishments. Chapter VI looks at the importance of monitoring and evaluation for the successful implementation of community-based programs and presents elements of a model
monitoring and evaluation plan for the HAA. Chapter VII analyses the replies submitted by the HOPWA funded HIV/AIDS service providers to the questionnaire designed to take stock of the present state of services in the District. Chapter VIII presents a strategic plan that analyses the vision, mission, goals and objectives of HAA and presents a set of actions to achieve these goals and objectives.
CHAPTER II
OVERVIEW OF HOMELESSNESS

Homelessness, poor housing conditions, and risk for homelessness occur at extraordinary rates among some HIV-positive populations. The U.S. Department of Housing and Urban Development cites estimates that one-third to one-half of all people living with AIDS “are either homeless or in imminent danger of losing their homes.” 9 Rapidly rising housing costs in many major cities are increasing the housing crisis among some HIV-positive subpopulations. Among more than 5000 people living with HIV/AIDS surveyed by AIDS Housing of Washington in 23 areas around the country since 1993, 41 percent indicated they had been homeless at some point in their lives.10 Reducing homelessness among persons living with HIV/AIDS is of particular importance. The absence of stable housing complicates matters for PLWHA, as in its absence they are unable to receive adequate healthcare or adhere to the strict regimen that AIDS treatment necessitates.

Homelessness touches every aspect of the lives of its victims. The state of being homeless is complicated by the fact that the homeless are almost always poor and many of them are afflicted with chronic emotional, physical, and family problems. As a result the homeless generally have low self-esteem, feel little sense of accountability, and suffer from hopelessness and lack of control. Homelessness results in an individual being isolated from the community and its family, social, and institutional networks. It is estimated that on any given night, 750,000 Americans are homeless, and up to 2 million are homeless at some point each year.11

Definition of a Homeless Person

The Federal definition of a homeless person is an individual who: (1) lacks a fixed, regular, and adequate nighttime residence; and (2) has a primary nighttime residence that is (a) a supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill), (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings. [McKinney Act (P.L. 100-77, sec 103(2)(1), 101 sat. 485 (1987)].


11 National Alliance to End Homelessness. Available at www.naeh.org
The 1990 Annual Report of the Interagency Council on the Homeless\textsuperscript{12} contained these facts about the homeless:

- More than 80 percent of all homeless families are headed by single women. Children under the age of 18 years account for 15 percent of the homeless population.
- Many homeless individuals are employed. Approximately 20 to 25 percent of all homeless persons receive some wage income although, on average, that income is insufficient to live on. As many as 25 percent of all homeless individuals are unemployable because of severe mental illness or physical disability.
- The duration of homelessness varies. Homeless families with children usually spend the least amount of time homeless, while more than half of all homeless adults remain homeless for 1 year or longer.

The U.S. Conference of Mayors, in its survey of homelessness in the Nation's cities in 1993, presented the following conclusions\textsuperscript{13} about the demographic characteristics of America's homeless:

- Families comprised an estimated 43 percent of the homeless population in 1993, which represents a significant 11-percent increase in the number of homeless families since 1992.
- The percentage of single youth increased from 2 percent to 4 percent between 1992 and 1993.
- Fifty-six percent of the homeless were African American, 27 percent white, 13 percent Hispanic, 3 percent Native American, and 1 percent Asian.
- Twenty-seven percent of the homeless were considered mentally ill, 48 percent were substance abusers, and 9 percent had AIDS or HIV-related illnesses.

In March 1994, the United States Department of Housing and Urban Development (HUD) offered the following observations in its profile of homeless persons\textsuperscript{14}:

- Single unattached adults, unaccompanied by children, make up about three-quarters of homeless persons. Men outnumber women by a factor of five.
- The average age of a homeless person is the late 30s; that of mothers with children is the early 30s.
- Minorities are disproportionately represented among the homeless population, especially among homeless families.

• Seventy-five percent of all homeless persons have been in an institutional setting for some period of time; this includes prison, inpatient chemical dependency treatment centers, and hospitals for mental disorders.
• At least half of the adult homeless population has an ongoing or past alcohol- or drug-related problem.
• Homeless persons are poor, having a spending income averaging less than $200 a month, regardless of household composition.
• As many as one-third of homeless children may not be attending school regularly.
• Of the entire male homeless population, approximately 30 to 45 percent are veterans

According to the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC):

• single homeless individuals in 1996 reported an average income of $348 during the last 30 days, about 51 percent of the 1996 federal poverty level of $680/month for one person;
• twenty eight percent said they sometimes or often do not get enough to eat;
• forty four percent reported having done paid work during the past month;
• twenty one percent had received income from family members or friends;
• sixty six percent of the homeless reported having problems with alcohol, drug abuse, or mental illness;
• twenty two percent have been physically assaulted;
• seven percent reported having been sexually assaulted;
• thirty eight percent reported that someone had stole money or things directly from them; and
• thirty percent reported that they have been homeless for more than two years.

The U.S. Conference of Mayors, in its survey of homelessness in the Nation's cities in 2004, presented the following conclusions15 about the demographic characteristics of America's homeless:

• During 2003, requests for emergency shelter increased in the survey cities by an average of six percent, with 70 percent of the cities registering an increase. Requests for shelter by homeless families alone increased by seven percent, with 78 percent of the cities reporting an increase.

15 A Status report on Hunger and Homelessness in America’s Cities: A 27 City Survey. December 2004. To assess the status of hunger and homelessness in America’s cities during 2004, The U.S. Conference of Mayors surveyed 27 major cities whose mayors were members of its Task Force on Hunger and Homelessness. The survey sought information and estimates from each city on 1) the demand for emergency food assistance and emergency shelter and the capacity of local agencies to meet that demand; 2) the causes of hunger and homelessness and the demographics of the populations experiencing these problems; 3) exemplary programs or efforts in the cities to respond to hunger and homelessness; 4) the availability of affordable housing for low income people; and 5) the outlook for the future and the impact of the economy on hunger and homelessness.
• The requests of 23 percent of homeless people in general and 32 percent of homeless families for emergency shelter are estimated to have gone unmet during the last 2003. In 81 percent of the cities, emergency shelters may have had to turn away homeless families due to lack of resources; in 81 percent they may also have had to turn away other homeless people.
• People remain homeless an average of eight months; 46 percent of the cities reported that the length of time people were homeless increased during 2003.
• Lack of affordable housing is the leading cause of homelessness in the surveyed cities. Other causes, in order of importance, include mental illness, substance abuse, low-paying jobs, unemployment, domestic violence, poverty, and prisoner re-entry.
• Officials estimate that, on average, single men comprise 41 percent of the homeless population, families with children comprise 40 percent, single women account for 14 percent and unaccompanied youth account for five percent of the homeless population.
• The homeless population is estimated to be 49 percent African-American, 35 percent white, 13 percent Hispanic, two percent Native American and one percent Asian.
• About 23 percent of all homeless people in the cities are considered mentally ill; 30 percent are substance abusers; 17 percent are unemployed; and 10 percent are veterans.
• In 56 percent of the cities, families may have had to break up in order to be sheltered. In 52 percent of the cities families may have to spend their daytime hours outside of the shelter they use at night.
• Requests for assisted housing by low-income families and individuals increased in 68 percent of the cities during 2003. Thirty-two percent of eligible low-income households are currently served by assisted housing programs. City officials estimate that low-income households spend an average of 45 percent of their income on housing.
• The survey found that applicants must wait an average of 20 months for public housing. The wait for Section 8 certificates is 30 months, and for Section 8 Vouchers 35 months. Fifty nine percent of the cities have stopped accepting applications for at least one assisted housing program due to the excessive length of the waiting list.

Homelessness and Federal Legislations

Homelessness dramatically increased in the 1980s. In the years which followed, advocates around the country demanded that the federal government acknowledge homelessness as a national problem requiring a national response. With this goal in mind, the Homeless Persons' Survival Act was introduced in both houses of Congress in 1986. This Act contained emergency relief measures, preventive measures, and long term solutions to homelessness. Only small pieces of this proposal, however, were enacted into law. The first, the Homeless Eligibility Clarification Act of 1986, removed permanent address requirements and other barriers to existing programs such as Supplemental Security Income, Aid to Families with Dependent Children, Veterans Benefits, Food
Stamps, and Medicaid. Also in 1986, the Homeless Housing Act was adopted. This legislation created the Emergency Shelter Grant program and a transitional housing demonstration program; both programs were administered by the Department of Housing and Urban Development.

In late 1986, legislation containing Title I of the Homeless Persons' Survival Act -- emergency relief provisions for shelter, food, mobile health care, and transitional housing -- was introduced as the “Urgent Relief for the Homeless Act.” After an intensive advocacy campaign, the legislation was passed by large bipartisan majorities in both houses of Congress in 1987. After the death of its chief Republican sponsor, Representative Stewart B. McKinney of Connecticut, the act was renamed the Stewart B. McKinney Homeless Assistance Act. It was signed into law by President Ronald Reagan on July 22, 1987.

The Stewart B. McKinney Act originally authorized 20 programs offering a multitude of services, including emergency food and shelter, transitional and permanent housing, education, job training, mental health care, primary health care services, substance abuse treatment, and veterans' assistance services. HUD had direct responsibility for administering five of the programs. A brief description of the five HUD-administered programs follows:

- **Emergency Shelter Grants (ESG) Program.** This program provides formula (block grant) funding for emergency shelter and essential services.
- **Supportive Housing Demonstration (SHDP) Program.** This competitive program funds a variety of grantees to provide transitional and permanent housing, particularly for homeless families and persons with special needs or handicaps. Initially funded as a demonstration, the program was renamed the Supportive Housing Program and made permanent in the Housing and Community Development Act of 1992.
- **Section 8 Moderate Rehabilitation for Single-Room Occupancy Dwellings.** This competitively awarded program provides funding to owners of SRO housing in the form of rental assistance payments on behalf of homeless individuals, in conjunction with the rehabilitation of the facility. The program provides permanent housing for previously homeless tenants.
- **Shelter Plus Care.** Congress added this program in FY 1990, and provided the first funding in FY 1992. Funds are competitively awarded for rental assistance. Grantees must match the value of rental assistance with an equal value of supportive services. The target population is homeless persons living on the streets or in emergency shelters with severe mental illness, chronic substance abuse problems, or AIDS.
- **Supplemental Assistance for Facilities to Assist the Homeless (SAFAH).** This competitive program funded innovative projects that met the immediate and long-term needs of the homeless, as well as projects already receiving funds under ESG and SHDP. The broad and flexible range of assistance permitted program expansion, capital improvement, and startup of new, needed supportive services. In 1992, SAFAH was incorporated into the Supportive Housing Program.
• **Single Family Property Disposition Initiative.** Originally, this program was not a McKinney program. It was created in 1983 under the HUD Secretary's broad legislative authority to dispose of single-family properties. In 1985, it was broadened to allow HUD to sell or lease foreclosed single-family properties to non-profit organizations, or to State or local governments to provide temporary shelter for homeless persons. In 1992, the Housing and Community Development Act recognized it as a McKinney initiative.

The next major legislation to meet the affordable housing needs of the low-income families was the Cranston-Gonzales National Affordable Housing Act of 1990. The Act’s purposes were:

- To help families not owning a home to save for a down payment for the purchase of a home;
- To retain wherever feasible as housing affordable to low-income families those dwelling units produced for such purpose with federal assistance;
- To extend and strengthen partnerships among all levels of government and the private sector, including for-profit and nonprofit organizations, in the production and operation of housing affordable to low-income and moderate-income families; and,
- To increase the supply of supportive housing, which combines structural features and services needed to enable persons with special needs to live with dignity and independence.


**Legislation on Housing and Other Services for PLWHA**

**Ryan White Comprehensive AIDS Resources Emergency (CARE) Act**

In 1991 the Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which provided the first formula grant funds for the care and treatment of PLWHA. The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services has lead responsibility for the administration of this Act. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is a federal legislation that addresses the unmet health needs of persons living with HIV disease by funding primary health care and support services that enhance access to and retention in care. The CARE Act works toward these goals by funding local and state programs that provide primary medical care and support services; healthcare provider training; and technical assistance to help funded programs address implementation and emerging HIV care issues. At the time it was enacted, The Ryan White CARE Act provided an emergency response to the devastating effects of HIV on individuals, families, communities, and state and local governments. The CARE Act signaled a comprehensive approach by targeting funds to respond to the specific needs of communities.
Title I/Part A — Emergency Relief Grant Program. Title I provides funds to eligible metropolitan areas (EMAs) that are severely affected by the HIV epidemic. Services supported by Title I grants include community-based outpatient medical and dental care, rehabilitative services, home health and hospice care, transportation and housing assistance, nutrition services, and respite care. The program is intended to assist low-income or under-insured people living with HIV. A portion of each grant must be spent on services for women, infants and children with HIV disease. In FY1991, the first year Title I grants were awarded, 16 EMAs were identified; by FY2002, the number of EMAs had increased to a total of 51.16

Title II/Part B — Care Grant Program. Title II awards formula grants to states and territories for home and community-based health care and support services. Services must be accessible to low-income individuals. Many states use Title II funds to provide services directly or through subcontracts with HIV care consortia. Consortia are associations of public and nonprofit health care and support service providers that assess needs and deliver services to individuals with HIV. Title II grants are also used to provide (1) health insurance coverage for low-income persons through Health Insurance Continuation Programs; and, (2) drug treatments under the AIDS Drug Assistance Programs (ADAPs) for individuals with HIV who have limited or no coverage from private insurance or Medicaid. Grants are awarded based on a formula that takes into account two factors: (1) the estimated number of living AIDS cases in the state; and (2) the estimated number of living AIDS cases in the state who are not in a Title I EMA.

Title III/Part C — Early Intervention Services. Title III provides early intervention grants to public and private nonprofit entities already providing primary care services to low-income and medically underserved people at risk for HIV. Title III grants are awarded to community and migrant health centers, homeless programs, local health departments, family planning programs, hemophilia diagnostic and treatment centers and other nonprofit community-based programs. Title III services include HIV testing, risk reduction counseling, case management, outreach, medical evaluation, transmission prevention, oral health, nutritional and mental health services, and clinical care.

Title IV/Part D — General Provisions. In its original enactment, Title IV authorized a number of different HIV-related programs; only one was ever funded: the pediatric demonstration grants. In the CARE Act’s 1996 reauthorization, the pediatric demonstration grant program was replaced with a program of grants for coordinated services and access to research for women, infants, children, and youth. The grants enhance access to and linkage with clinical research supported by the National Institutes

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16 Eligible metropolitan areas (EMAs) are defined as those with more than 2,000 reported AIDS cases in the past 5 years and a population of at least 500,000. The Number of EMAs tripled from 16 in 1991 to 51 in 2004. There are EMAs in 22 States, Puerto Rico, and the District of Columbia. Each EMA establishes a Planning Council to assess local needs, set priorities, and develop a comprehensive plan for providing services.
of Health (NIH), and are to be made in coordination with the NIH activities. The grants provide opportunities for women, infants, children, and youth to be voluntary participants in research of potential clinical benefit to individuals with HIV. Such individuals are provided health care on an outpatient basis, case management, referrals, transportation, child care, and other incidental services to enable participation.

*Titles I, II and IV of the Ryan White CARE Act allow housing-related assistance as eligible expenditures.* Funds received under the Act may be used for the following expenditures:

- Housing referral services defined as assessment, search, placement, and advocacy services;
- Short term or emergency housing necessary to gain or maintain access to medical care related to housing services that include some type of medical or supportive service, residential foster care, and assisted living residential services; and/or housing services that do not provide direct medical or supportive services but are essential for an individual or a family to gain or maintain access and compliance with HIV related medical care and treatment.

**Table 1**

Federal Funding for the Ryan White CARE Act ($ in millions)

<table>
<thead>
<tr>
<th>FY</th>
<th>Title I</th>
<th>Title II</th>
<th>ADAP</th>
<th>Title III</th>
<th>Title IV</th>
<th>Part F AETC</th>
<th>Part F ADR</th>
<th>Total &amp;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>87.8</td>
<td>87.8</td>
<td>—</td>
<td>44.9</td>
<td>19.5</td>
<td>17.0</td>
<td>—</td>
<td>257.0</td>
</tr>
<tr>
<td>1992</td>
<td>121.6</td>
<td>107.6</td>
<td>—</td>
<td>48.7</td>
<td>19.3</td>
<td>16.9</td>
<td>—</td>
<td>314.1</td>
</tr>
<tr>
<td>1993</td>
<td>184.8</td>
<td>115.3</td>
<td>—</td>
<td>48.0</td>
<td>20.9</td>
<td>16.4</td>
<td>—</td>
<td>385.4</td>
</tr>
<tr>
<td>1994</td>
<td>325.5</td>
<td>183.9</td>
<td>—</td>
<td>48.0</td>
<td>22.0</td>
<td>16.4</td>
<td>7.0</td>
<td>602.8</td>
</tr>
<tr>
<td>1995</td>
<td>356.5</td>
<td>198.1</td>
<td>—</td>
<td>52.0</td>
<td>26.0</td>
<td>16.3</td>
<td>6.9</td>
<td>655.8</td>
</tr>
<tr>
<td>1996</td>
<td>391.7</td>
<td>260.8</td>
<td>(52)</td>
<td>57.0</td>
<td>29.0</td>
<td>12.0</td>
<td>6.9</td>
<td>757.4</td>
</tr>
<tr>
<td>1997</td>
<td>449.8</td>
<td>417.0</td>
<td>(167)</td>
<td>69.6</td>
<td>36.0</td>
<td>16.3</td>
<td>7.5</td>
<td>996.3</td>
</tr>
<tr>
<td>1998</td>
<td>464.7</td>
<td>542.8</td>
<td>(285.5)</td>
<td>76.2</td>
<td>40.8</td>
<td>17.2</td>
<td>7.8</td>
<td>1,150.2</td>
</tr>
<tr>
<td>1999</td>
<td>505.0</td>
<td>737.7</td>
<td>(461.0)</td>
<td>94.3</td>
<td>46.0</td>
<td>20.0</td>
<td>7.8</td>
<td>1,410.9</td>
</tr>
<tr>
<td>2000</td>
<td>546.3</td>
<td>823.8</td>
<td>(528.0)</td>
<td>138.4</td>
<td>50.0</td>
<td>26.6</td>
<td>8.0</td>
<td>1,594.6</td>
</tr>
<tr>
<td>2001</td>
<td>604.2</td>
<td>910.9</td>
<td>(589.0)</td>
<td>185.9</td>
<td>65.0</td>
<td>31.6</td>
<td>10.0</td>
<td>1,807.6</td>
</tr>
<tr>
<td>2002</td>
<td>619.4</td>
<td>977.2</td>
<td>(639.0)</td>
<td>193.8</td>
<td>71.0</td>
<td>35.3</td>
<td>13.5</td>
<td>1,910.2</td>
</tr>
<tr>
<td>FY2003*</td>
<td>618.7</td>
<td>1,053.4</td>
<td>(714.3)</td>
<td>198.4</td>
<td>73.6</td>
<td>35.6</td>
<td>13.4</td>
<td>1,993.0</td>
</tr>
<tr>
<td>FY2004*</td>
<td>615.0</td>
<td>1,085.9</td>
<td>(748.9)</td>
<td>197.2</td>
<td>73.1</td>
<td>35.3</td>
<td>13.3</td>
<td>2,019.9</td>
</tr>
</tbody>
</table>

*Source:* DHHS FY2006 Health Resources and Services Administration Justification of Estimates for Appropriations Committees.

&: Total may not add due to rounding.

* The total does not include an additional $25 million set-aside for evaluations. The $25 million set-aside is funded through an evaluation tap of amounts appropriated under the Public Health Service Act (PHSA). In 2003, the evaluation tap was 2.1%, as specified in conference report.
H.Rept.108-10; in 2004, the evaluation tap was 2.2%, as specified in conference report H.Rept.108-401.

**FY2005 Conference amounts do not include the 0.80% offset required by P.L.108-447. The FY2005 Conference total does not include an additional $25 million set-aside for evaluations. The $25 million set-aside is funded through a 2.4% evaluation tap of amounts appropriated under the PHSA, as specified in conference report H.Rept.108-792.

*** FY2005 Comparable amounts do not include the 0.80% offset required by P.L.108-447. The 2005 Comparable total does not include an additional $25 million set-aside for evaluations.

**** FY2006 Request total does not include an additional $25 million set-aside for evaluations.

In 2002, 319,295 clients received outpatient medical care through CARE Act–funded providers, almost four times the number receiving any other service except case management17. The number of clients relying on those providers for outpatient medical care illustrates the inability of other public programs to meet demand. Many essential support services funded through the CARE Act are directly related to primary health care. For example, services such as treatment adherence counseling, health education risk reduction, nutritional counseling, and food bank/home-delivered meals are inextricably linked to the health status of people living with HIV and AIDS because such supports help keep people in care. Table 2 presents the gender, age, ethnicity, and race of clients who received CARE Act services in 2002.

Table 2  
Gender, Age, Ethnicity, and Race of Clients Who Received CARE Act Services

<table>
<thead>
<tr>
<th></th>
<th>HIV-positive</th>
<th>HIV-affected</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>571,378</td>
<td>68%</td>
<td>95,928</td>
</tr>
<tr>
<td>Female</td>
<td>264,562</td>
<td>31%</td>
<td>84,225</td>
</tr>
<tr>
<td>Transgender</td>
<td>4,085</td>
<td>1%</td>
<td>3,781</td>
</tr>
<tr>
<td>Unknown/unreported</td>
<td>4,662</td>
<td>1%</td>
<td>15,551</td>
</tr>
<tr>
<td>Total</td>
<td>844,687</td>
<td>100%</td>
<td>199,485</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 2 years</td>
<td>3,230</td>
<td>&lt;1%</td>
<td>7,581</td>
</tr>
<tr>
<td>2 - 12 years</td>
<td>13,105</td>
<td>2%</td>
<td>17,005</td>
</tr>
<tr>
<td>13 - 24 years</td>
<td>34,529</td>
<td>4%</td>
<td>32,630</td>
</tr>
<tr>
<td>25 - 44 years</td>
<td>504,665</td>
<td>60%</td>
<td>70,437</td>
</tr>
<tr>
<td>45 - 64 years</td>
<td>267,270</td>
<td>32%</td>
<td>34,934</td>
</tr>
<tr>
<td>65+ years</td>
<td>11,260</td>
<td>1%</td>
<td>2,752</td>
</tr>
<tr>
<td>Unknown/unreported</td>
<td>10,628</td>
<td>1%</td>
<td>34,146</td>
</tr>
<tr>
<td>Total</td>
<td>844,687</td>
<td>100%</td>
<td>199,485</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino(a)</td>
<td>167,439</td>
<td>20%</td>
<td>45,090</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>631,102</td>
<td>75%</td>
<td>117,252</td>
</tr>
<tr>
<td>Unknown/unreported</td>
<td>46,146</td>
<td>6%</td>
<td>37,143</td>
</tr>
<tr>
<td>Total</td>
<td>844,687</td>
<td>100%</td>
<td>199,485</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>299,123</td>
<td>35%</td>
<td>57,076</td>
</tr>
<tr>
<td>Black or African American</td>
<td>388,835</td>
<td>46%</td>
<td>82,336</td>
</tr>
<tr>
<td>Asian</td>
<td>7,988</td>
<td>1%</td>
<td>1,688</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>1,204</td>
<td>&lt;1%</td>
<td>108</td>
</tr>
<tr>
<td>Native American/Alaska Native</td>
<td>5,500</td>
<td>1%</td>
<td>702</td>
</tr>
<tr>
<td>More than one race</td>
<td>30,365</td>
<td>4%</td>
<td>6,698</td>
</tr>
<tr>
<td>Unknown/unreported</td>
<td>111,672</td>
<td>13%</td>
<td>50,877</td>
</tr>
<tr>
<td>Total</td>
<td>844,687</td>
<td>100%</td>
<td>199,485</td>
</tr>
</tbody>
</table>

Source: HRSA\textsuperscript{18}

Organizations providing one or more health care and/or case management service report the number of clients receiving each service as well as the total number of visits per service. Table 3 presents the total number duplicated clients served and the number of visits reported by CARE Act providers during 2002 for each health care service and case management. Case management services and outpatient/ambulatory medical care services were the most frequently utilized CARE Act services in 2002. CARE Act case management providers reported serving 332,377 HIV-positive clients. More than 3.6 million client visits were recorded by the CARE Act providers delivering case management services to HIV-positive clients. Case management services include activities such as initial assessment of service needs; development of a comprehensive, individualized service plan; coordination of client services; and periodic re-evaluation and adaptation of the individualized service plan over the life of the client.

**Table 3**

**Health Care and Case Management Services, Ryan White CARE Act, 2002**

<table>
<thead>
<tr>
<th>Health Care Services</th>
<th>Number of Duplicated Clients Served</th>
<th>Total Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory/Outpatient Medical Care</td>
<td>319,295</td>
<td>2,099,774</td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>81,437</td>
<td>609,314</td>
</tr>
<tr>
<td>Oral Health Care</td>
<td>71,504</td>
<td>219,045</td>
</tr>
<tr>
<td>Substance Abuse Services, outpatient</td>
<td>36,084</td>
<td>630,175</td>
</tr>
<tr>
<td>Substance Abuse Services, residential</td>
<td>3,292</td>
<td>153,250</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>1,300</td>
<td>14,530</td>
</tr>
<tr>
<td>Home health: paraprofessional care</td>
<td>3,865</td>
<td>171,991</td>
</tr>
<tr>
<td>Home health: professional care</td>
<td>2,998</td>
<td>55,226</td>
</tr>
<tr>
<td>Home health: specialized care</td>
<td>858</td>
<td>10,448</td>
</tr>
<tr>
<td>Case management services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-positive clients</td>
<td>332,377</td>
<td>3,689,838</td>
</tr>
<tr>
<td>HIV-affected clients</td>
<td>23,854</td>
<td>124,254</td>
</tr>
</tbody>
</table>

**Source:** HRSA\(^{19}\)

\(^{19}\) Ibid
CARE Act providers deliver an array of supportive services to HIV affected clients. Table 4 presents the total number of clients that received each service.

Table 4
Number of clients receiving support services through CARE Act, 2002

<table>
<thead>
<tr>
<th>Services</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food bank, home delivered meals</td>
<td>113,673</td>
</tr>
<tr>
<td>Client advocacy</td>
<td>113,363</td>
</tr>
<tr>
<td>Treatment adherence counseling</td>
<td>111,716</td>
</tr>
<tr>
<td>Transportation services</td>
<td>100,185</td>
</tr>
<tr>
<td>Health education, risk reduction</td>
<td>91,948</td>
</tr>
<tr>
<td>Psychological support services</td>
<td>87,414</td>
</tr>
<tr>
<td>Referral health care/Support services</td>
<td>86,690</td>
</tr>
<tr>
<td>Other services</td>
<td>84,707</td>
</tr>
<tr>
<td>Emergency financial assistance</td>
<td>74,965</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>73,089</td>
</tr>
<tr>
<td>Outreach services</td>
<td>49,247</td>
</tr>
<tr>
<td>Housing services</td>
<td>46,037</td>
</tr>
<tr>
<td>Legal services</td>
<td>21,679</td>
</tr>
<tr>
<td>Referral clinical research</td>
<td>20,745</td>
</tr>
<tr>
<td>Early intervention Title II</td>
<td>9,638</td>
</tr>
<tr>
<td>Buddy/companion services</td>
<td>8,729</td>
</tr>
<tr>
<td>Permanency planning</td>
<td>5,596</td>
</tr>
<tr>
<td>Day/Respite care for adults</td>
<td>5,049</td>
</tr>
<tr>
<td>Child care</td>
<td>3,230</td>
</tr>
<tr>
<td>Developmental assessment</td>
<td>2,856</td>
</tr>
<tr>
<td>In-home hospice care</td>
<td>1,245</td>
</tr>
<tr>
<td>Child welfare services</td>
<td>939</td>
</tr>
</tbody>
</table>

Source: HRSA

The Housing Opportunities for Persons Living With HIV/AIDS (HOPWA) Program

The HOPWA Program was established as part of the National Affordable Housing Act of 1990. Administered by HUD, HOPWA was designed to address the targeted needs of persons living with HIV/AIDS and their families. HOPWA is authorized by statute “to provide States and localities with resources and incentive to devise long-term, comprehensive strategies for meeting the housing needs of persons with acquired
immunodeficiency syndrome and families of such persons.”20 Grants are made to local communities, States, and nonprofit organizations for projects that benefit low income persons medically diagnosed with HIV/AIDS and their families. HOPWA remains the only Federal program solely dedicated to providing housing assistance to PLWHA and their families.

HOPWA funding provides housing assistance and related supportive services as part of HUD’s Consolidated Planning initiative that works in partnership with communities and neighborhoods in managing Federal funds appropriated to HIV/AIDS programs. HOPWA grantees are encouraged to develop community-wide strategies and form partnerships with area nonprofit organizations.

HOPWA funds are awarded as grants from one of three programs:

The HOPWA Formula Program: The Program uses a statutory method to allocate HOPWA funds to eligible States and cities on behalf of their metropolitan areas.

The HOPWA Competitive Program: The program is a national competition to select model projects or programs.

The HOPWA National Technical Assistance Program: Under this Program Funding awards are provided to strengthen the management, operation, and capacity of HOPWA grantees, project sponsors, and potential applicants of HOPWA funding.

The number of jurisdictions that qualify for a formula allocation has grown from 97 in 1999 to 111 in 2003. HUD estimates this number may further grow to 114 by 2004.

HOPWA funds may be used for a wide range of housing, social services, program planning, and development costs. These include, but are not limited to:

- Housing information services, including counseling and referral services to help eligible individuals locate, acquire, finance, and maintain housing;
- Acquisition, rehabilitation, conversion, lease, and repair of facilities;
- New construction of community residences and single room occupancy units;
- Project or tenant-based rental assistance, including assistance for shared housing arrangements;
- Short-term rent, mortgage, and utility payments to prevent the homelessness of the tenant or owner of a dwelling;
- Operating costs for housing, including maintenance, security, operation, insurance, utilities, furnishings, supplies, and other incidentals;
- Supportive services (health care, mental health treatment, substance abuse treatment and counseling, nutritional services, and case management).

All HOPWA formula funds are available as part of an area’s Consolidated Plan, which also includes the Community Development Block Grant, HOME Investment Partnership Program, and Emergency Shelter Grants.

HOPWA funds have helped many communities establish strategic AIDS housing plans, better coordinate local and private efforts, fill gaps in local systems of care, and create new housing resources. In assisting low-income persons who are living with HIV or AIDS and their families avoid homelessness, grantees have provided for a wide-array of housing, social services and program planning and development activities undertaken in connection with health-case, AIDS Drug Assistance and other support offered through community-wide efforts. Program activities have also helped to address the objectives of the National AIDS Strategy which established national goals to end the epidemic of HIV and AIDS and to ensure that all people living with HIV have access to services, from health care to housing and supportive services that are affordable, of high quality, and responsive to their needs. HUD estimated that the fiscal year 2004 HOPWA appropriation of $257.6 million would provide housing assistance to about 74,250 households that include eligible persons living with HIV/AIDS and their family members who reside with them. According to HUD estimates, 60 percent of HOPWA funds are expended directly on housing assistance for clients, such as rental assistance, short-term rent, mortgage assistance and utility payments to prevent homelessness. It is also estimated that approximately 22 percent of HOPWA funds are used for supportive services in connection with housing activities. Supportive services are defined as including, but not limited to health, mental health, assessment, permanent housing placement, drug and alcohol abuse treatment and counseling, day care, nutritional services, intensive care when required, and assistance in gaining access to local, state, and Federal government benefits and services. While most HOPWA funds are dedicated to tenant-based rental assistance, funds are also used for construction, rehabilitation, and acquisition of housing. For the reporting year 2000, 800 units were created using 6.5 percent of funds for that year.

HOPWA funding during the years 2001 to 2004 is presented in Table 5.

21 HOPWA. Available at http://www.federalgrantswire.com/housing_opportunities_for_persons_with_aids.html. Accessed on 6/22/05
23 Ibid.
A national evaluation of the HOPWA program was undertaken by the Department of Housing and Urban Development Office of Policy development and Research. The findings issued in January 2001 noted: 24

- The HOPWA program predominantly serves the “poorest of the poor”, persons with extremely low-incomes and very low-incomes who are living with HIV/AIDS, including many people with additional burdens such as mental illness and substance abuse;
- The HOPWA program’s flexibility helps meet clients’ housing needs and preferences primarily in the form of tenant-based rental assistance and short-term payments for rent;
- The HOPWA program enhances clients’ housing thereby helping them increase their ability to focus on maintaining good health and adhering to medical regimens;
- 92 percent of HOPWA grantees and housing providers also coordinated with Ryan White CARE Act and HUD’s Continuum of Care systems in planning and setting priorities;
- On average, each dollar used for HOPWA housing assistance is being combined with $2.19 from other government and private sources for housing development and housing operating expenses;
- Clients are largely satisfied with the housing they receive in terms of housing stability, adequate housing, and quality of life.

In addition to the HOPWA program, people living with HIV/AIDS who meet the program requirements (e.g. low-income, homelessness, etc.) are eligible for any HUD program for which they might otherwise qualify, including public housing, Section 8 housing assistance, Community Development Block Grants, and the Continuum of Care Homeless Assistance programs. If a person has been diagnosed with AIDS, he or she is disabled and may qualify for many HUD programs in addition to HOPWA. The following may address specialized needs of persons with HIV/AIDS:

Shelter Plus Care (S+C)

This program combines HUD-supported rental assistance with supportive services provided by other sources on a matching basis for homeless persons with disabilities. "Recipients may establish a preference as part of their admissions procedures for one or more of the statutorily targeted populations (seriously mentally ill, alcohol or substance abusers, or persons with AIDS and related diseases)."

Supportive Housing Program (SHP)

Under SHP, public entities and nonprofit organizations may receive funds for transitional and permanent housing and/or supportive services to people who are homeless, including permanent housing for persons with disabilities, such as homeless persons who are living with HIV/AIDS. Funds may be used for capital costs, facility operations, and supportive service costs. Projects must contribute a share of program costs from nonfederal sources and match services (25%).

Section 811

The Supportive Housing for Persons with Disabilities Program (Section 811) provides financial assistance in the form of capital advances and project rental assistance to nonprofit sponsors to expand the supply of housing for very low income persons with disabilities. Projects may provide assistive services addressing the needs of persons disabled by HIV/AIDS. The provider must demonstrate that an applicant can live more independently if housed in a Section 811 project.

Section 202

The Supportive Housing for the Elderly Program (Section 202) may be used to serve persons who are living with HIV/AIDS who are at least 62 years of age.

Section 8 Rental Assistance

Some communities have established local preferences for housing assistance through the Section 8 program for persons with terminal illnesses, including HIV/AIDS, or persons with an immunological disorder of a degenerative nature, such as AIDS or HIV disease. In these communities, other persons who can make use of the accessible features or service program of the project (e.g. a person with a terminal illness not related to HIV infection) may also receive priority for available Section 8 vouchers.

The HOME Program

The HOME Investments Partnerships Program (HOME) is a flexible community resource for housing development for low and very-low income people. Based on local decision-making processes, "The participating jurisdiction may establish a preference for individuals with special needs. The participating jurisdiction may offer, in conjunction
with a tenant-based rental assistance program, particular types of non-mandatory services that may be most appropriate for persons with a special need or a particular disability. Generally, tenant-based rental assistance and the related services should be made available to all persons with special needs or disabilities who can benefit from such services. The participating jurisdiction may also provide a preference for a specific category of individuals with disabilities (e.g., persons with HIV/AIDS or chronic mental illness) if the specific category is identified in the participating jurisdiction's consolidated plan as having unmet need and the preference is needed to narrow the gap in benefits and services received by such persons." [24 CFR sec. 92.209(c)(3)].

**Other Government Funding Sources for Housing**

The following list provides some sources of financing for affordable housing other than HOPWA and Ryan White CARE programs. Although these two programs provide dedicated funds for housing, they alone are insufficient to develop and operate housing. The other sources of funds listed here are not exhaustive. It highlights some major programs directly related to housing for PLWHA.

**U.S. Department of Housing and Urban Development**

*Emergency Shelter Grants*
A block grant program administered by state and local governments to improve the quality of existing shelters and transitional housing for homeless people, create additional emergency shelters, to pay for certain operating expenses towards supportive services, and other assistance to homeless people.

*Community Development Block Grants*
CDBG is a block grant program administered by state and local governments to carry out a wide range of community development activities including property acquisition and rehabilitation.

*Section 8 Moderate Rehabilitation Single Room Occupancy Dwellings Program*
A rental assistance program in which HUD contracts with local authorities to enable the moderate rehabilitation of residential properties that, when completed, will contain multiple single room dwelling units. The local authorities make rental assistance payments to the landlords on behalf of the homeless individuals who rent the rehabilitated dwellings. The assistance covers operating expenses and debt service of non-profit agencies or public housing authorities that rehabilitate single room occupancy housing.

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25 For further details check out AIDS Housing of Washington website, [wwwaidshousing.org](http://wwwaidshousing.org).
Supportive Housing for Persons with Disabilities (Section 811)
A capital advance and rental assistance program for non-profit organizations administered by HUD to provide supportive housing for very low-income people who have disabilities (including those who have disabilities resulting from HIV infection). The support services should address the resident’s individual needs, provide optimal independent living, and provide access to the community and employment opportunities.

Section 8 Mainstream Housing Opportunities for People with Disabilities
A rental assistance program that provides vouchers and certificates to enable persons with disabilities to rent affordable private housing of their choice.

Federally Owned Single-Property Disposition Help to the Homeless
A program to lease or sell federally owned single-family properties to non-profit organizations and public agencies to assist homeless people.

Federal Surplus Property for Use to Assist the Homeless
A program through which the federal government leases or deeds surplus properties to organizations for use in assisting homeless people.

Mortgage Insurance for Nursing Homes, Intermediate care facilities, Board and Care homes, and Assisted Living Facilities (Section 232)
A mortgage insurance program used to finance the construction, acquisition, and/or rehabilitation of nursing homes, intermediate care facilities, board and care homes, and assisted living facilities, serving people who need special nursing care or a protective living environment but not hospitalization.

U.S. Department of Health and Human Services

Projects for Assistance in Transition from Homelessness (PATH)
A grant program to provide funds for a wide range of support services, including housing services, for those who have severe mental illnesses and are homeless or are at risk of homelessness.

Runaway and Homeless Youth Program, Transitional Living Program for Youth
This program provides grants for housing and a range of services for up to 18 months for youth ages 16 to 21.

Health Care for the Homeless
A competitive grant program that provides primary care and substance abuse services to the homeless. The program also provides assistance with accessing other services, including housing.
**U.S. Department of Veteran Affairs**

*Homeless Providers Grant and Per Diem Program*
Grants to promote the development and provision of supportive housing and/or appropriate supportive services to assist homeless veterans in transition from homelessness, enabling them to live as independently as possible.

**U.S. Department of Agriculture**

*Rural Rental and Cooperative Housing Loans (Section 515)*
Direct loans to finance rental or cooperatively owned housing for low- and moderate-income families, the elderly, and/or disable residents in rural areas.

*Rural Rental Assistance Program (Section 521)*
Similar to HUD Section 8 rental assistance programs; includes rental, cooperative and farm labor housing.

**Other Funding Sources**

*Low-Income Housing Tax Credit Programs*
A formula allotment of federal income tax credits administered by states and distributed to developers of and investors in low-income rental housing. The tax credit allows qualified owners of or investors in eligible low-income rental housing to reduce their federal income taxes on a dollar-for-dollar basis for a ten year period, subject to compliance. Low-income housing developers use these credits to attract investors, who commit to funding a project in return for tax credit.

*Historic Tax Credits*
Federal tax credits for developers and investors to preserve and rehabilitate historic buildings.

*State Housing Finance Programs*
Programs Operated by state-chartered agencies responsible for administering low-income housing funds allocated by state governments.

*Affordable Housing Finance programs of Government-Chartered Corporations*
These housing finance corporations have particular obligations to address the housing needs of the nation in exchange for special federal government status.
CHAPTER III

TRENDS IN THE EPIDEMIOLOGY OF HIV/AIDS

In the early eighties when the disease was first identified, HIV was largely confined to males, Caucasians, and men who have sex with men (MSM). During the entire decade, AIDS cases and resulting deaths from the disease in the nation continued to rise at an alarming rate and peaked in the early nineties. Throughout the 1990s, there was a noticeable decline in new cases; however, during this period, there was a noticeable shift in the demographics of those infected with the disease. Higher incidences of AIDS among Blacks, Hispanics, and women were registered. AIDS was no longer a disease affecting the gay white male community as the disease spread among the blacks, heterosexuals and females. It also became primarily a poverty related disease as many affected individuals and families were increasingly from low- and very low-income sections of population.

African Americans continue to be most severely affected by AIDS in the U.S. In 2003, rates of AIDS cases were 58.2 per 100,000 among African Americans, 20.0 per 100,000 among Hispanics, 8.1 per 100,000 among American Indian/Alaska Natives, 6.1 per 100,000 among whites, and 4.0 per 100,000 among Asian/Pacific Islanders. In 2003, the highest rate of HIV diagnosis was among African American males (103.4 per 100,000 population), with a rate almost seven times that of white males (15.2 per 100,000) and nearly three times the rate among Hispanic males (40.4 per 100,000). The rate of HIV diagnosis among African American females in 2003 (53 cases per 100,000 population) was more than 18 times higher than among white females (2.9 per 100,000) and almost five times higher than among Hispanic females (10.9 per 100,000). Among American Indians/Alaska Natives, the rate of HIV diagnosis among males (15.6 per 100,000) was slightly higher than the rate among white males; the rate among females (6.4 per 100,000) was twice the rate of white females. According to the Centers for Disease Control and Prevention (CDC) cultural, socioeconomic, and health-related factors, in addition to barriers to risk reduction, may continue to drive the HIV epidemic in communities of color.

In any discussion on the prevalence of HIV/AIDS nationally, the following critical issues need to be considered:

- Evidence indicates a resurgence of risky behavior and extraordinarily high seroprevalence rates in recent times particularly among the MSM, mostly due to advanced medical treatment options. According to the CDC, the increase in HIV diagnoses among MSM may also be linked to a rise in use of crystal methamphetamine (crystal meth) among MSM. Crystal meth is a powerful, illicit drug that can reduce inhibitions and has been associated with high-risk behaviors and sexually transmitted diseases in multiple studies.

- Many HIV-positive individuals in treatment are poorer than the general population. The HIV Cost and Services Utilization Study found that “compared with others in the non-elderly population, adult patients with HIV were about half
as likely to be employed, to have a household income above the 25th percentile, or to have private insurance.”

- Blacks are likely to live in poverty and remain uninsured compared to other groups. In the two year period, 1999–2000, 23.9 percent of blacks lived below the poverty line as compared to 9.9 percent of whites, and 18.5 percent of blacks were uninsured as compared to 12.9 percent of whites.

- In a 2000 survey, blacks ranked AIDS as the number one health issue facing the nation, tied with cancer (41 percent); however, this was a lesser percentage than in 1995, when 56 percent said that AIDS was the nation’s most urgent health issue.

- HIV-positive blacks, Hispanics, women, and individuals without private insurance continued to be less likely than whites to receive the care they need.

- Blacks are more likely to live in medically underserved areas than whites; almost two-thirds of community and migrant health center patients are racial and ethnic minorities.

### Status of HIV/AIDS in the District of Columbia

AIDS surveillance in the District began in July of 1983, when reporting was mandated under the Preventive Health Services Administration of the Commission of Public Health. This profile is largely based on the “District of Columbia HIV/AIDS Epidemiologic Profile 2001” produced by the DC Department of Health HIV/AIDS Administration.

### Geographic, Social, Economic, and Demographic Characteristics

In order to gain a clear understanding of the prevalence of HIV/AIDS and how it affects the District of Columbia population, we first consider the socio economic conditions in the District of Columbia (See Table 6)

#### Table 6

**Socio Economic Indicators: District of Columbia**

<table>
<thead>
<tr>
<th>Demographic indicators</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>572,059</td>
</tr>
<tr>
<td>Male</td>
<td>269,366 (47.1%)</td>
</tr>
<tr>
<td>Female</td>
<td>302,693 (52.9%)</td>
</tr>
</tbody>
</table>
### Table 6 (continued)

**Socio Economic Indicators: District of Columbia**

<table>
<thead>
<tr>
<th>Demographic Indicators</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>176,101 (30.8%)</td>
</tr>
<tr>
<td>Black</td>
<td>343,312 (60.0%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>44,953 (7.9%)</td>
</tr>
<tr>
<td>Asian</td>
<td>13,709 (2.7%)</td>
</tr>
<tr>
<td>American Indian</td>
<td>909 (0.3%)</td>
</tr>
<tr>
<td><strong>Educational attainment (25 years of age and above)</strong></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>370,464</td>
</tr>
<tr>
<td>High school graduate or higher</td>
<td>81.70%</td>
</tr>
<tr>
<td>Bachelors’ degree or higher</td>
<td>41.10%</td>
</tr>
<tr>
<td><strong>Marital status (15 years of age or above)</strong></td>
<td></td>
</tr>
<tr>
<td>Males - never married</td>
<td>49.75%</td>
</tr>
<tr>
<td>Females – never married</td>
<td>45.99%</td>
</tr>
<tr>
<td><strong>Civilian labor force (population 16 years of age and above)</strong></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>291,676</td>
</tr>
<tr>
<td>Employed</td>
<td>268,695</td>
</tr>
<tr>
<td>Unemployed</td>
<td>22,981</td>
</tr>
<tr>
<td>Rate of unemployment</td>
<td>7.90%</td>
</tr>
<tr>
<td><strong>Household income</strong></td>
<td></td>
</tr>
<tr>
<td>Total number of households</td>
<td>248,590</td>
</tr>
<tr>
<td>Median household income</td>
<td>$41,047</td>
</tr>
<tr>
<td>Households with social security income</td>
<td>48,388 (19.4%)</td>
</tr>
<tr>
<td>Households with supplementary security income</td>
<td>11,521 (4.6%)</td>
</tr>
<tr>
<td>Households with public assistance income</td>
<td>13,664 (5.5%)</td>
</tr>
<tr>
<td><strong>Poverty levels</strong></td>
<td></td>
</tr>
<tr>
<td>Persons below poverty level</td>
<td>19.30%</td>
</tr>
<tr>
<td>Children below poverty level</td>
<td>33.70%</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
</tr>
<tr>
<td>Total housing units</td>
<td>274,845</td>
</tr>
<tr>
<td>1-unit</td>
<td>108,590</td>
</tr>
<tr>
<td>2 units</td>
<td>15,575</td>
</tr>
<tr>
<td>3 or 4 units</td>
<td>22,266</td>
</tr>
<tr>
<td>5 to 9 units</td>
<td>17,108</td>
</tr>
<tr>
<td>10 to 19 units</td>
<td>28,434</td>
</tr>
<tr>
<td>20 or more units</td>
<td>82,679</td>
</tr>
<tr>
<td>Occupied housing units</td>
<td>243,947</td>
</tr>
<tr>
<td>Renter-occupied units</td>
<td>147,684</td>
</tr>
<tr>
<td>Median contract rent</td>
<td>$636</td>
</tr>
</tbody>
</table>

Some important observations that emerge from Table 6 are:

- A majority of the District’s population (60 percent) is African American.
- About eighteen percent of the District population (ages 25 and above) do not have a high school degree.
- Nearly half the men and women living in the District have never married, suggesting that there are a large number of children living in single parent families.
- The rate of unemployment in the District, at nearly eight percent, is much higher than it is for the nation as a whole.
- Nearly thirty percent of households in the District receive some form of public assistance income.
- The percentage of persons below poverty level is high --- 150 percent more that of the national average, while the percentage of children below poverty level is 169 percent of the national average.
- Nearly sixty percent of the occupied housing units are renter-occupied.

**HIV/AIDS Epidemiological Profile**

The District of Columbia struggles with a number of health-related issues, of which high HIV/AIDS rate is one of the most prominent. HIV/AIDS is the third leading cause of death in the District for blacks, after heart disease and cancer. However, AIDS remains the leading cause of death among black women ages 25-44.

The District of Columbia accounts for 0.25 percent of the total US population.26 However the AIDS cases reported by the District authorities through 2001 accounted for 2.44 percent of all cases reported in the country. This disproportionate prevalence of AIDS among District residents is also evident when we consider the rate of AIDS cases. The AIDS case rate per 100,000 population in the US as whole in 2002 was 14.8 whereas it was 162.4 for the District. Among cities with populations larger than 500,000, D.C. has the highest rate of AIDS cases – 119 per 100,000 followed by Baltimore (117 cases per 100,000), San Francisco, New York and Philadelphia, at 67, 64 and 58 cases per 100,000 population respectively.27 Table 7 presents the District AIDS surveillance data for the period ending September 2002.

---

26 According to US Census, 2000 the US population stood at 225,981,679 and that of DC was 572,059.
### Table 7

AIDS Surveillance Data

<table>
<thead>
<tr>
<th>Demographic Group</th>
<th>Cumulative incidence as of 9/30/02</th>
<th>AIDS as of 9/30/02</th>
<th>AIDS Death as of 9/30/02</th>
<th>Living with AIDS as of 9/30/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity</td>
<td>Numbers % of Total</td>
<td>Numbers % of Total</td>
<td>Numbers % of Total</td>
<td>Numbers % of Total</td>
</tr>
<tr>
<td>White</td>
<td>2,895 20.5</td>
<td>1,691 25.5</td>
<td>1,204 16</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>10,739 75.9</td>
<td>4,762 71.8</td>
<td>5,977 79.6</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>455 3.2</td>
<td>165 2.5</td>
<td>290 3.9</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>45 0.3</td>
<td>10 0.2</td>
<td>35 0.5</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>8 0.05</td>
<td>3 0.05</td>
<td>5 0.07</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>14,142 100</td>
<td>6,631 100</td>
<td>7,511 100</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11,400 80.6</td>
<td>5,653 85.3</td>
<td>5,747 76.5</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2,742 19.4</td>
<td>978 14.7</td>
<td>1,764 23.5</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>14,142 100</td>
<td>6,631 100</td>
<td>7,511 100</td>
<td></td>
</tr>
<tr>
<td>Age at Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;13</td>
<td>175 1.2</td>
<td>82 1.2</td>
<td>93 1.2</td>
<td></td>
</tr>
<tr>
<td>13-19</td>
<td>63 0.4</td>
<td>16 0.2</td>
<td>47 0.6</td>
<td></td>
</tr>
<tr>
<td>20-44</td>
<td>10,690 75.6</td>
<td>5,005 75.5</td>
<td>5,685 75.7</td>
<td></td>
</tr>
<tr>
<td>&gt;44</td>
<td>3,147 22.3</td>
<td>1,486 22.4</td>
<td>1,661 22.1</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>67 0.5</td>
<td>42 0.6</td>
<td>25 0.3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>14,142 100</td>
<td>6,631 100</td>
<td>7,511 100</td>
<td></td>
</tr>
<tr>
<td>Exposure Category</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult/Adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>6,887 49.3</td>
<td>3,770 57.6</td>
<td>3,117 42</td>
<td></td>
</tr>
<tr>
<td>Injection drug users</td>
<td>3,756 26.9</td>
<td>1,634 25</td>
<td>2,122 28.6</td>
<td></td>
</tr>
<tr>
<td>Men who have sex with men and inject drugs</td>
<td>643 4.6</td>
<td>376 5.7</td>
<td>267 3.6</td>
<td></td>
</tr>
<tr>
<td>Heterosexual contact</td>
<td>1,822 13.1</td>
<td>535 8.2</td>
<td>1,287 17.4</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>115 0.8</td>
<td>63 1</td>
<td>52 0.7</td>
<td></td>
</tr>
<tr>
<td>Risk not reported</td>
<td>738 5.3</td>
<td>170 2.6</td>
<td>568 7.7</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>13,961 100</td>
<td>6,548 100</td>
<td>7,413 100</td>
<td></td>
</tr>
<tr>
<td>Pediatric</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother with/at risk</td>
<td>170 93.9</td>
<td>78 94</td>
<td>92 93.9</td>
<td></td>
</tr>
<tr>
<td>Other pediatrics</td>
<td>11 6.1</td>
<td>5 6</td>
<td>6 6.1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>181 100</td>
<td>83 100</td>
<td>98 100</td>
<td></td>
</tr>
</tbody>
</table>

Source: Data, Planning and Evaluation Division HIV/AIDS Administration, District of Columbia Department of Health, AIDS Surveillance Update, Volume 22, No. 1, 2003:6

In order to get a fuller understanding of the severity and extent of AIDS cases in the District, it is necessary to look at some major indicators of the epidemic in D.C. and compare them with national data. A comparative look at the status of HIV/AIDS in the U.S. and D.C. is presented in Table 8.
Table 8
HIV/AIDS Status in the U.S. and the District of Columbia: A Comparative Study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>D.C.</th>
<th>U.S.A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative number of AIDS cases reported through December 2001</td>
<td>13,969</td>
<td>816,149</td>
</tr>
<tr>
<td>As a % of total population</td>
<td>2.44%</td>
<td>0.36%</td>
</tr>
<tr>
<td>Percentage distribution of cumulative adult/adolescent cases by sex reported through June 2002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>81%</td>
<td>82%</td>
</tr>
<tr>
<td>Female</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Percentage distribution of cumulative Adult/Adolescent AIDS cases by Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>20.7%</td>
<td>42.1%</td>
</tr>
<tr>
<td>Black</td>
<td>75.7%</td>
<td>38.4%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3.2%</td>
<td>18.3%</td>
</tr>
<tr>
<td>AIDS case rate/100,000 population in 2001</td>
<td>152.1</td>
<td>14.9</td>
</tr>
<tr>
<td>White</td>
<td>113.1</td>
<td>8.1</td>
</tr>
<tr>
<td>Black</td>
<td>260.1</td>
<td>76.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>102.6</td>
<td>31.4</td>
</tr>
<tr>
<td>Male</td>
<td>275.7</td>
<td>28.1</td>
</tr>
<tr>
<td>Female</td>
<td>92.0</td>
<td>9.12</td>
</tr>
<tr>
<td>Estimated number of people living with AIDS at the end of 2001</td>
<td>7,497</td>
<td>362,684</td>
</tr>
<tr>
<td>Male</td>
<td>76%</td>
<td>78%</td>
</tr>
<tr>
<td>Female</td>
<td>24%</td>
<td>22%</td>
</tr>
<tr>
<td>White</td>
<td>15.6%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Black</td>
<td>79.9%</td>
<td>41.8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3.9%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Percentage of persons aged 18-64 who reported having received an HIV test in the preceding 12 months, in 2001</td>
<td>37%</td>
<td>27.7%</td>
</tr>
</tbody>
</table>

AIDS cases in the District of Columbia increased annually through 1993 and then fell till 2000. However, the AIDS cases have registered an increase since 2001. The trend in the growth of AIDS cases between 1984 and 2002 is presented in Figure 1.

**Figure 1**

**AIDS Cases Diagnosed through December 2002**

The reasons for increases in the number of HIV diagnosis and newly acquired HIV infection in the District of Columbia may be attributed to a number of reasons. The limited evidence available suggests the following reasons:

- Increasing risk behavior among gay and homosexually active men and an association of risk behavior with the optimism about apparent effectiveness of new treatments;
- The issue of late diagnosis among some subpopulations leading to increased infectivity in these individuals;
- Increasing rates of sexually transmitted infections that act as co-factors in HIV transmission;
- Current health promotion and prevention initiatives not reaching some sections of the community that are at high risk of HIV infection.

**Racial Perspective**

We also notice a racial disproportionality in the incidence of AIDS among the District of Columbia’s population. Blacks account for sixty percent of the population but 75.7 percent of AIDS cases reported in 2001. Figure 2 shows the percent of persons living with AIDS by ethnicity.
An estimated 7,500 people were living with AIDS in the District as of the end of 2001. Nearly seventy five percent of the AIDS population is estimated to be black. White and Hispanic populations account for sixteen percent and four percent respectively of the AIDS population living in D.C. As for cumulative AIDS cases reported through December 2001, seventy six percent are black, twenty one percent are white and three percent are Hispanics.

Hispanics constitute nearly eight percent of the D.C. population and nearly four percent of AIDS cases. Small though this may be small numerically, they face special challenges. On average Hispanics tend to be poorer, lack health insurance, and live below poverty level. Uninsured immigrants avoid seeking care because they cannot afford to pay for medical services. They wait till their illness has progressed into stages that require hospitalization or nursing home care. Although Ryan White CARE Title I provides for free services to both legal immigrants and the undocumented, many are unaware that these services exist. Even when they are aware of these services, they may be reluctant to access them due to fear that they may be reported to authorities and deported. The other problems they face are ones related to cultural and language barriers. These challenges may prevent them from discussing issues related to their sexual orientation, health, family or other issues such as housing with service providers. The language barrier may also make it difficult for them to understand the medical and treatment regimens thereby making it difficult for them to adhere to the prescribed medications.

Distribution of cumulative AIDS cases by race-ethnicity is presented in Figure 3.
Figure 3

Cumulative AIDS cases according to race

Gender

The number of women living with AIDS makes up about 25 percent of total living cases in the District. Adult/adolescent women diagnosed with AIDS account for 20 percent of the cumulative cases reported through December 2002 and 29 percent of cases reported between 1998 and 2002. Since 1993, AIDS cases reported among women have grown at a rate faster than that for men. The rate of growth of women diagnosed with AIDS has been growing at a rate faster than that for men. In fact, the rate of growth in diagnosed AIDS cases among men has been falling for the last few years. This has resulted in the closing of the gap between the male cases and female cases. Figure 4 presents growth in AIDS cases among men and women.

Figure 4

Distribution of AIDS Cases by Gender
Some other important AIDS related facts as applicable to D.C. are:

- About eighty eight percent of cumulative AIDS cases reported comprise those in the age group 20 to 49.

- The majority of deaths occurred in the age groups of 25 to 54, accounting for eighty seven percent in 1999. However, deaths from AIDS declined by sixty two percent relative to 1996, sixty five percent among males and fifty one percent among females. Blacks accounted for eighty one percent of the deaths and whites for seventeen percent of the deaths.

- Though relatively small in number, Hispanic cases remained constant in the 1990s. Considering that the number of cases overall are falling, this constant rate indicates a relatively rising trend among this group of population.

- There has also been a disproportionate rise in the AIDS cases reported by females in the District. Since 1993, AIDS cases reported by women have grown at a rate faster than that reported by men. Women account for twenty six percent of the cases reported between 1996 and 2000 as against sixteen percent reported between 1990 and 1995. Between 1996 and 2000, the number of cases reported by women aged 13-19 rose by thirty three percent, that of women aged 19-24 and 25 and above rose by thirty seven percent and forty two percent respectively. IDU and heterosexual contact accounted for forty five percent and forty two percent respectively of exposure modes among newly reported cases in black women. While the number of cases reported by females increased by ten percent during 1996-2000, the number of cases reported by males has continued to decline over the same period.

- Results from the D.C. surveys indicate that HIV seroprevalence among childbearing women was 6 to 7 times higher than the rate for childbearing women nationwide.

- 167 pediatric cases of AIDS were reported between 1981 and 2000; of these eighteen percent were reported in the 1980s and eighty two percent in the 1990s registering a 415 percent increase in a decade. About eighty five percent of the children were under age 5 and another fifteen percent were between ages 5 and 12 at the time of their initial diagnosis with AIDS. Almost all AIDS cases among children were attributed to perinatally acquired HIV infection from maternal risk behavior.

- Among teenagers first diagnosed with AIDS, fifty eight percent were females and forty two percent were males. Heterosexual contact accounted for fifty three percent of these cases. Among teenage girls, seventy six percent of the cases were attributed to heterosexual contact; and for teenage boys, fifty two percent of AIDS cases were attributed to male-to-male sexual contact.
Among male adult/adolescent AIDS cases reported, the predominant mode of transmission was men having sex with men (MSM) at fifty percent. The other causes are injection/intravenous drug use (IDU) at twenty seven percent and heterosexual contact at eleven percent. Among MSM cases reported between 1996 and 2000, sixty six percent were black and twenty seven percent were white.

In sum, the District of Columbia has the highest rate of AIDS cases per 100,000 population nationally. The demographics of those affected by the disease have changed in the last decade. African Americans continue to be the most severely affected by AIDS in the District. However, the adult/adolescent women diagnosed with AIDS is growing at a rate faster than ever before. The disease is found among low-income groups living in poverty disproportionately. Although MSM continues to be the predominant mode of transmission, injection drug use and heterosexual contact are growing concerns.

**Geographic Distribution of AIDS cases in the District of Columbia**

Just as there is an uneven distribution of AIDS cases among different regions within the country, there is an uneven distribution of HIV/AIDS geographically within the District. AIDS prevalence rates and how they affect men and women varies between the eight wards. In the period 1996-2000, while only two percent of all AIDS cases lived in Ward 3, Ward 1 accounted for seventeen percent of cases. Wards 1, 2, 5, and 6 have the highest number of recently reported AIDS cases. Of the cumulative AIDS cases, the homeless and prisoners account for seven percent each, and those with unknown residence account for three percent.

This distribution of AIDS cases across D.C. wards is in and of itself an interesting study. The variations in terms of income, race/ethnicity and age composition of the population, and poverty rates between the wards is significant. Forr instance, while Ward 3 is the richest ward with a median household income of $71,875, it has the fewest number of AIDS cases (93). On the other hand, Ward 5 has a median household income of $34,433, but has reported the highest (617) AIDS cases. Similarly, while 7.4 percent of Ward 3 population lives below poverty level, twenty percent of Ward 5 population does so. The data indicate a high correlation between AIDS cases in wards and their poverty levels. As the District population increasingly witness gentrification of many areas, the low-income population are the worst affected as they are the ones who often get displaced, forcing them to move into areas with a higher concentration of poverty. Table 9 presents selected demographic characteristics of the wards.
Table 9

Demographic and Socio-economic Data by D.C. Wards

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>City</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>572,509</td>
<td>73,364</td>
<td>68,869</td>
<td>73,718</td>
<td>74,092</td>
<td>72,527</td>
<td>68,035</td>
<td>70,540</td>
<td>70,914</td>
</tr>
<tr>
<td>(% of total)</td>
<td>100%</td>
<td>12.80%</td>
<td>12.00%</td>
<td>12.00%</td>
<td>12.80%</td>
<td>12.60%</td>
<td>11.60%</td>
<td>12.30%</td>
<td>12.30%</td>
</tr>
<tr>
<td>White (%)</td>
<td>30.8</td>
<td>31.7</td>
<td>65.4</td>
<td>83.6</td>
<td>17.7</td>
<td>9.4</td>
<td>31.6</td>
<td>1.4</td>
<td>5.3</td>
</tr>
<tr>
<td>Black (%)</td>
<td>60</td>
<td>45.7</td>
<td>19.9</td>
<td>5.8</td>
<td>70.7</td>
<td>86.7</td>
<td>62.7</td>
<td>96.8</td>
<td>92.4</td>
</tr>
<tr>
<td>Youth (0-17)</td>
<td>114,992</td>
<td>13,102</td>
<td>5,513</td>
<td>8,817</td>
<td>15,691</td>
<td>15,328</td>
<td>11,654</td>
<td>19,420</td>
<td>25,464</td>
</tr>
<tr>
<td>(% of total)</td>
<td>20</td>
<td>17.8</td>
<td>8</td>
<td>11.9</td>
<td>21.1</td>
<td>21.1</td>
<td>17.1</td>
<td>27.5</td>
<td>35.9</td>
</tr>
<tr>
<td>Median income ($)</td>
<td>40,127</td>
<td>36,902</td>
<td>44,742</td>
<td>71,875</td>
<td>46,408</td>
<td>34,433</td>
<td>41,554</td>
<td>30,533</td>
<td>25,017</td>
</tr>
<tr>
<td>Per capita income ($)</td>
<td>28,659</td>
<td>23,760</td>
<td>42,660</td>
<td>58,584</td>
<td>27,057</td>
<td>19,173</td>
<td>28,636</td>
<td>16,959</td>
<td>12,630</td>
</tr>
<tr>
<td>Below poverty level</td>
<td>20.20%</td>
<td>22.00%</td>
<td>18.70%</td>
<td>11.90%</td>
<td>21.10%</td>
<td>21.10%</td>
<td>17.10%</td>
<td>24.90%</td>
<td>36.00%</td>
</tr>
<tr>
<td>Drug use (%)</td>
<td>8.9</td>
<td>12.6</td>
<td>14.1</td>
<td>2.7</td>
<td>3.0</td>
<td>14.0</td>
<td>5.3</td>
<td>12.3</td>
<td>11.3</td>
</tr>
</tbody>
</table>


The distribution of AIDS cases by wards is presented in Table 10.

Table 10

Distribution of living AIDS cases by Ward (through 12/31/2002)

<table>
<thead>
<tr>
<th>WARDS</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Homeless</th>
<th>Inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,361</td>
<td>1,195</td>
<td>189</td>
<td>786</td>
<td>1,007</td>
<td>1,088</td>
<td>726</td>
<td>809</td>
<td>439</td>
<td>388</td>
</tr>
<tr>
<td>Males</td>
<td>1,076 (79%)</td>
<td>1,002 (83.8%)</td>
<td>166 (87.8%)</td>
<td>605 (76.9%)</td>
<td>742 (73.6%)</td>
<td>853 (78.4%)</td>
<td>458 (63%)</td>
<td>483 (59.7%)</td>
<td>351 (79.9%)</td>
<td>338 (87.1%)</td>
</tr>
<tr>
<td>Females</td>
<td>285 (21%)</td>
<td>193 (16.2%)</td>
<td>23 (12.2%)</td>
<td>181 (23.1%)</td>
<td>265 (26.4%)</td>
<td>235 (21.6%)</td>
<td>268 (37%)</td>
<td>326 (40.3%)</td>
<td>88 (20.1%)</td>
<td>50 (12.9%)</td>
</tr>
</tbody>
</table>


HIV/AIDS cases living in the eight wards of D.C. is presented in Figure 5.
The distribution of AIDS cases among women among the wards is also skewed. There are more women living with HIV/AIDS in Wards 7 and 8 than in others. The ward-wise distribution of AIDS cases by gender is presented in Figure 6.
Neighborhoods included in Wards with high incidence of HIV/AIDS

Ward 1: Shaw, Columbia Heights, Mount Pleasant
Ward 2: Foggy Bottom, Georgetown, Dupont Circle, Logan Circle, Buzzard Point
Ward 5: Michigan Park, Brookland, Queen’s Chapel, Woodridge, Fort Lincoln
Ward 6: Benning Road, Stadium/Armory, Eastern Market, Twining/Greenway

Although AIDS cases fell in all the wards between 1983 and 2000, this fall was not uniform across the wards. Some wards such as Ward 3 witnessed a dramatic fall in AIDS cases (74%) while other wards such as Wards 7 and 8 witnessed a fall in AIDS cases of only 13 percent and 10 percent respectively. Table 11 presents the temporal change in AIDS cases in the District wards.

### Table 11


<table>
<thead>
<tr>
<th></th>
<th>Ward 1</th>
<th>Ward 2</th>
<th>Ward 3</th>
<th>Ward 4</th>
<th>Ward 5</th>
<th>Ward 6</th>
<th>Ward 7</th>
<th>Ward 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983-1995</td>
<td>1487 (20.3%)</td>
<td>1452 (19.8%)</td>
<td>355 (4.8%)</td>
<td>738 (10.1%)</td>
<td>944 (12.9%)</td>
<td>1184 (16.2%)</td>
<td>565 (7.7%)</td>
<td>579 (7.9%)</td>
</tr>
<tr>
<td>1996-2000</td>
<td>777 (18.1%)</td>
<td>648 (15.1%)</td>
<td>93 (2.1%)</td>
<td>451 (10.5%)</td>
<td>617 (14.4%)</td>
<td>670 (15.6%)</td>
<td>493 (11.5%)</td>
<td>523 (12.2%)</td>
</tr>
<tr>
<td>Total</td>
<td>2,264 (19.7%)</td>
<td>2,100 (18.2%)</td>
<td>448 (3.9%)</td>
<td>1,189 (10.3%)</td>
<td>1,561 (13.6%)</td>
<td>1,854 (16.1%)</td>
<td>1,058 (9.2%)</td>
<td>1,102 (9.6%)</td>
</tr>
<tr>
<td>Change (%)</td>
<td>(-) 48</td>
<td>(-) 55</td>
<td>(-) 74</td>
<td>(-) 39</td>
<td>(-) 35</td>
<td>(-) 43</td>
<td>(-) 13</td>
<td>(-) 10</td>
</tr>
</tbody>
</table>

An interesting fact emerges when we juxtapose the change in AIDS cases and the change in poverty levels over time within these wards. Those wards which registered a fall in poverty levels (wards 1, 3 and 6) also saw the biggest fall in AIDS cases. Wards 7 and 8 which saw considerable growth in poverty rates between 1970 and 2000, witnessed the least fall in the AIDS cases. The disparity in the decrease in AIDS cases across the wards may be explained by the growth in poverty rates in wards where the fall has been smaller. Table 12 shows that the Wards 7 and 8 which witnessed the smallest percentage fall in AIDS cases registered the largest increase in poverty rates between 1970 and 2000.
Table 12

Percentage change in poverty rates - 1970 to 2000

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>22.2</td>
<td>19.7</td>
<td>22.0</td>
<td>-&lt;1</td>
</tr>
<tr>
<td>2</td>
<td>20.7</td>
<td>20.9</td>
<td>18.7</td>
<td>-9</td>
</tr>
<tr>
<td>3</td>
<td>5.8</td>
<td>6.8</td>
<td>7.4</td>
<td>+27.5</td>
</tr>
<tr>
<td>4</td>
<td>9.1</td>
<td>9.0</td>
<td>12.0</td>
<td>+31.8</td>
</tr>
<tr>
<td>5</td>
<td>15.9</td>
<td>15.6</td>
<td>20.0</td>
<td>+25.7</td>
</tr>
<tr>
<td>6</td>
<td>21.4</td>
<td>16.5</td>
<td>21.1</td>
<td>-&lt;1</td>
</tr>
<tr>
<td>7</td>
<td>17.6</td>
<td>20.3</td>
<td>24.9</td>
<td>+41.4</td>
</tr>
<tr>
<td>8</td>
<td>17.1</td>
<td>28.2</td>
<td>36.0</td>
<td>+110.5</td>
</tr>
</tbody>
</table>

Source: US Bureau of Census.

The disproportionate impact of the HIV/AIDS epidemic among racial and ethnic minority communities presents special challenges and calls for a range of interventions that specifically target this group. The impact of HIV/AIDS within these communities is further compounded by social and economic factors that include the socio-cultural role of women, poverty, crime and violence, and homelessness. It is imperative, therefore, to identify the cultural, racial, social and economic contexts within which HIV/AIDS transmission is facilitated, and make considered decisions on what needs to be done to limit/prevent transmission, and monitor carefully the impacts of interventions within these communities.

It is necessary to develop, test, evaluate and disseminate culturally sensitive and appropriate prevention interventions in racial and ethnic minority communities to reduce HIV transmission and acquisition in at-risk social networks. The institutions that may best serve as entry points into these communities are faith-based and community-based organizations. Community-based projects that target medically underserved ethnic and minority populations need to be encouraged.

There have been significant advances in HIV therapy including protease inhibitor therapy and other potent therapies. The benefits derived from these therapies are not uniformly distributed across different communities impacted by HIV infection. Further, the impact of comorbidities such as sexually transmitted disease (STD) and hepatitis C among these communities also need special attention.

There is a need for an active research agenda that encourages exploring how social forces affect individuals, groups, and communities and their ability to protect against HIV infection. Such research should pay special attention to women and adolescents, and gay and bisexual men of color who suffer from drug and alcohol abuse in addition to engaging in risky sexual behavior. Research on alternative support structures designed to increase adherence and improved health outcomes, especially for the homeless and mentally ill.
CHAPTER IV

HOMELESSNESS AND AFFORDABLE HOUSING IN THE DISTRICT OF COLUMBIA

Affordability remains America’s most widespread housing challenge. The shortage of affordable housing directly affects the quality of life for millions who eke out their housing payments every month, sacrifice the purchase of other essentials, commute long distances to work, and/or suffer overcrowded or unsafe conditions. Worse yet, some must live in shelters or on the street. These pressures not only undermine their physical and mental health, but also their ability to find suitable work, perform well in school, and advance economically.
- Harvard University.28

“Housing affordability (brings) together in a single term a number of issues: the distribution of housing prices, the distribution of housing quality, the distribution of income, the ability of households to borrow, public policies affecting housing markets, conditions affecting the supply of new or refurbished housing, and the choices that people make about how much housing to consume relative to other goods. This mixture of issues raises difficulties in interpreting even basic facts about housing affordability.”
- John M. Quigley and Steven Raphael.29

In 2003 an estimated 16,000 to 17,500 people in the District of Columbia were homeless at some point during the year and as many as 2,000 of these were ‘chronically homeless’ persons who lived either in shelters or on the streets throughout the year.30 At the last point-in-time enumeration undertaken in January 2004 by the Metropolitan Washington Council of Governments, about 8,250 persons were within the D.C. homeless continuum of care. About 6,100 of these persons were on the streets, in shelters or in transitional facilities.

There are currently enough public and private beds to shelter or house about 8,875 persons, or to serve 1-in-13 of all District residents living in poverty.31 Although District’s publicly supported homeless system has grown in size and become more diverse in its composition, homelessness has continued to grow since 2002. The D.C. Housing Authority has a waiting list of about 16,000 households for Housing Choice Vouchers.32

31 Ibid.
32 Ibid. Housing choice vouchers allow very low-income families to choose and lease or purchase safe, decent, and affordable privately-owned rental housing. Various types of vouchers are: conversion vouchers, family unification vouchers, homeownership vouchers, project based vouchers, tenant based vouchers, vouchers for people with disabilities and welfare-to-work vouchers.
As long-run income growth among lower-income households stagnates and housing costs rise, housing affordability faces persistent challenges in many parts of the country. Being employed no longer guarantees that people will find homes they can afford, in places they want to live. Based on HUD’s fair market rent measure, households with one full-time minimum wage earner cannot afford to rent even a one-bedroom apartment anywhere in the country. Even households well above the full-time equivalent of the minimum wage are struggling to find housing that meets their needs, at costs they can afford. Meanwhile, the already scarce supply of smaller, less costly housing is shrinking, with especially sharp losses among two- to four-unit apartment buildings.33

In most metropolitan cities, including Washington, D.C., there is an acute shortage of affordable housing for low-income people in general.34 Market rate housing is now out of reach for low-income residents as a result of increased housing prices. A recent study found that despite unprecedented economic growth in the late 1990s, renters in the bottom quarter of income distribution actually saw their real income fall between 1996 and 1998, while their rents increased.35 A 1998 HUD publication36 reported that the average waiting time for public housing was 33 months, the average waiting time for Section 8 housing was 28 months, and major cities including Washington, D.C. had waiting lists of five to ten years.

The National Low Income Housing Coalition highlights these facts: 37

- In District of Columbia, a low-income household can afford monthly rent of no more $636, while the HUD determined Fair Market Rent (FMR) for a two bedroom unit is $1,218, for a one bedroom unit is $1,039 and no bedroom unit is $913.
- A minimum wage earner (earning $6.15 per hour) can afford monthly rent of no more than $320. Two people working full-time at the federal minimum wage cannot afford the FMR for a two bed-room apartment.
- A person receiving Supplemental Security Income ($552 monthly) can afford monthly rent of no more than $166, while the FMR for a one bedroom unit is $1,039. This means that a person could pay their entire SSI income toward rent and still not be able to rent an apartment at the FMR.
- A worker earning the minimum wage must work 152 hours per week in order to afford a two bedroom unit, 130 hours per week to afford a one bedroom unit, and 114 hours to afford a no bedroom unit at the area’s FMR.
- The amount a full time (40 hours per week) worker must earn per hour in order to afford a two-bedroom unit at the area’s FMR is $23.42 (381% of the minimum

wage), while it is $19.98 and $17.56 for a one-bedroom unit and no-bedroom unit respectively.

Fair Market Rent has been rising steadily over the last five years. The rise between 2000 and 2005 has approximately been 50 percent. This increase, without a corresponding rise in income levels of the low-income population has made home affordability more difficult. Table 13 presents the FMR for DC for the period 2000 to 2005.

### Table 13

**Fair Market Rents by unit bedrooms: District of Columbia. 2000 - 2005**

<table>
<thead>
<tr>
<th>FMR Year</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$630</td>
<td>$716</td>
<td>$840</td>
<td>$1,145</td>
<td>$1,380</td>
</tr>
<tr>
<td>2001</td>
<td>$680</td>
<td>$773</td>
<td>$907</td>
<td>$1,236</td>
<td>$1,491</td>
</tr>
<tr>
<td>2002</td>
<td>$707</td>
<td>$804</td>
<td>$943</td>
<td>$1,285</td>
<td>$1,550</td>
</tr>
<tr>
<td>2003</td>
<td>$865</td>
<td>$984</td>
<td>$1,154</td>
<td>$1,573</td>
<td>$1,897</td>
</tr>
<tr>
<td>2004</td>
<td>$913</td>
<td>$1,039</td>
<td>$1,218</td>
<td>$1,660</td>
<td>$2,002</td>
</tr>
<tr>
<td>2005</td>
<td>$915</td>
<td>$1,045</td>
<td>$1,187</td>
<td>$1,537</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

Source: HUD

The challenge of affordability appears starkly in the data showing the annual income needed to afford these units. (See Table 14).

### Table 14

**Annual income needed to afford housing units in the District of Columbia**

<table>
<thead>
<tr>
<th>Year</th>
<th>Zero</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$27,200</td>
<td>$30,920</td>
<td>$36,280</td>
<td>$49,440</td>
<td>$59,640</td>
</tr>
<tr>
<td>2002</td>
<td>$28,280</td>
<td>$32,160</td>
<td>$37,720</td>
<td>$51,400</td>
<td>$62,000</td>
</tr>
<tr>
<td>2003</td>
<td>$34,600</td>
<td>$39,360</td>
<td>$46,160</td>
<td>$62,920</td>
<td>$75,880</td>
</tr>
<tr>
<td>2004</td>
<td>$36,520</td>
<td>$41,560</td>
<td>$48,720</td>
<td>$66,400</td>
<td>$80,080</td>
</tr>
<tr>
<td>2005</td>
<td>$34,880</td>
<td>$39,680</td>
<td>$44,960</td>
<td>$57,800</td>
<td>$76,760</td>
</tr>
</tbody>
</table>

Source: HUD

Note: Annual Income assumes households can afford to pay 30% of monthly income on rent.

---

According to the U.S. Census Bureau\textsuperscript{39}, in the District of Columbia, out of total households of 245,785, 60,175 (24.4\%) households have extremely low income (0-30\% of median income); 33,246 (13.5\%) households have very low income (30 – 50\% of median Income); 31,153 (12.6\%) households have low income (50-80\% of median income); and 121,211 (49.5\%) households have moderate to high income (80\%+ of the median income). Considering that the median household income for the District of Columbia is $40,127 (Census 2000), about 40\% of the households have income less than 50 percent of the median income. When this fact is considered along with the fact that the annual income needed to afford even a one bedroom housing unit in the District in 2005 is $39,680, the extent and seriousness of housing affordability problem in the District becomes very clear.

The increases in the median rent-to-income ratio, coupled with the increase in the proportion of households in the higher rent-to-income ratio, suggest that inequality in rent burdens has increased over time. The proportion of income allocated to housing costs is far larger among low-income renters than high-income renters. The most extreme rent burdens are observed for the poorest households.

There is another paradox in the matter of housing affordability. As quality of rental housing improves, whether due to the demand from renters or government rules, rents rise, making units that were once affordable now unaffordable. Similarly, land-use regulations may reduce housing availability by allocating land away from residential uses\textsuperscript{40}.

Apart from the important issues of availability and affordability of housing, there are several other barriers to obtaining housing for low-income households including PLWHA. Some of the barriers are discussed below:

- The first barrier to accessing housing includes poor credit, poor rental history, and/or criminal background. Many PLWHA have had problems with substance abuse and many have criminal records. Most property managers are reluctant to provide housing to people who have convictions in their recent history. It is common for low-income people to have poor credit and/or rental histories. Such persons are screened out automatically by housing providers and property managers.
- The second factor is the practice of mortgage lending discrimination and discrimination in acceptance of applications for rental housing\textsuperscript{41}.
- The third factor is the lack of experience by occupants of rental housing in the complexities of becoming a first-time home buyer.
- The fourth factor that is emerging as a barrier to housing among Hispanics particularly is the issue of undocumented immigrants. In addition to language and

\textsuperscript{40} Thorson, James A. The Effect of Zoning on Housing Construction. \textit{Journal of Housing Economics}, Volume 6, Number 1. 1997:81-91.
\textsuperscript{41} Consolidated Plan for the District of Columbia. D.C. Department of Housing and Community Development.
cultural barriers, the undocumented immigrants are not likely to approach any
government organization for housing assistance for fear of deportation.

- Fifthly, those seeking housing may have an insufficient knowledge of
organizations in their community that provide assistance in finding transitional
shelter or housing.

Other barriers may include factors such as availability of finance for housing deposits
and ownership of pets.

A study by Shelter Partnership, Inc. California\(^{42}\) ranked the top seven barriers to
accessing housing by PLWHA:

1. insufficient funds to pay for housing;
2. rental assistance not enough to obtain safe and affordable housing;
3. non availability of sufficient appropriate housing options;
4. poor rental and credit history;
5. lack of knowledge of what is available or how to access available housing;
6. long and/or difficult application process; and
7. not being sober.

Apart from the questions of housing affordability and other barriers to obtaining housing,
there is also the question of maintaining the housing once obtained. Experience shows
that PLWHA may move a number of times because they can not pay the rent. Many of
them are either employed off and on or are unemployed/underemployed. While
fluctuating health is the primary reason for unemployment or sporadic employment, lack
of employment skills is also an important factor. Another important factor is the fall in
real income as income earned from work is rarely enough to offset the benefits they
would have received from Social Security Income (SSI) or Supplemental Security
Disability Income (SSDI). This often acts as a disincentive for these people to find and
keep jobs. However, in recognition of this disincentive factor, the Congress enacted the
Ticket to Work and Work Incentives Improvement Act in 1999. This program allows
persons with disabilities to return to work by increasing choices in obtaining
rehabilitation and vocational services.

State of Housing in the District of Columbia

In this section we look at the state of housing in the District of Columbia and the
accessibility and affordability of housing, with special reference to PLWHA. We also
analyze the housing gap, taking into account the demand for and supply of housing.
Many of the issues discussed in this section are equally applicable to all people with low
incomes. But housing is considered a particularly important issue for PLWHA as studies
have shown that other services have very little or no impact on this population in the
absence of stable housing.

\(^{42}\) Shelter Partnership, Inc. A Strategic Plan for Providing HIV/AIDS Housing with Supportive Services in Los Angeles
County, September 2003: 29.
Some overall housing statistics, as of 2000, relating to D.C. are discussed in the following paragraphs. The housing statistics are presented in Tables 15 to 21 and Figures 7 to 11.

**Table 15**

**Housing in the District of Columbia**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total housing units</td>
<td>274,845</td>
</tr>
<tr>
<td>Occupied units</td>
<td>248,338</td>
</tr>
<tr>
<td>Owner occupied</td>
<td>101,214 (40.8%)</td>
</tr>
<tr>
<td>Renter occupied</td>
<td>147,124 (59.2%)</td>
</tr>
<tr>
<td>Vacant Units</td>
<td>24,253 (8.9%)</td>
</tr>
<tr>
<td>Median rooms</td>
<td>4.7</td>
</tr>
<tr>
<td>Median rent</td>
<td>$636</td>
</tr>
</tbody>
</table>

Source: Census 2000.

**Housing Units in Structure**

There are a total of 274,845 housing units in the District of Columbia. Of these, single units account for 108,590 units or forty percent of the total housing units. The next biggest component of units consists of housing complexes with 20 or more units. There are 82,679 such units and account for thirty (30) percent of housing units. The rest of the thirty percent is accounted for by housing with 2 to 19 units. Housing units in structure are presented in Table 16 and Figure 7.

**Table 16**

**Housing units in structure**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total units</td>
<td>274,845</td>
</tr>
<tr>
<td>1 unit, detached</td>
<td>33,997</td>
</tr>
<tr>
<td>1 unit, attached</td>
<td>74,593</td>
</tr>
<tr>
<td>2 units</td>
<td>15,575</td>
</tr>
<tr>
<td>3 or 4 units</td>
<td>22,266</td>
</tr>
<tr>
<td>5 to 9 units</td>
<td>17,108</td>
</tr>
<tr>
<td>10 to 19 units</td>
<td>28,434</td>
</tr>
<tr>
<td>20 or more units</td>
<td>82,679</td>
</tr>
</tbody>
</table>

Source: Census 2000
The rents for rental housing units in D.C. have risen dramatically in the last few years. This increase is partly due to the gap in the housing demand and supply and partly due to the gentrification that has been taking place in the District. Housing affordability is becoming an issue as close to fifty percent of households pay more than thirty percent of their income – a cut off point set by the Department of Housing and Urban Development for affordability – toward rent.

According to the Census Bureau, thirty one percent of households pay 15-24 percent of their incomes as rent, twenty seven percent of households pay 20-29 percent of their incomes as rent, thirty percent of households pay 25-34 percent of their incomes as rent and thirty (30) percent households pay more than thirty five percent of their income as rent. Table 17 and figure 8 present statistics on gross rent paid by D.C. households toward housing.

### Table 17

<table>
<thead>
<tr>
<th>Percentage of Income</th>
<th>No. of Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 15%</td>
<td>27,246</td>
</tr>
<tr>
<td>15.0 to 19.9%</td>
<td>22,075</td>
</tr>
<tr>
<td>20.0 to 24.9%</td>
<td>21,202</td>
</tr>
<tr>
<td>25.0 to 29.9%</td>
<td>16,216</td>
</tr>
<tr>
<td>30.0 to 34.9%</td>
<td>11,052</td>
</tr>
<tr>
<td>35% or more</td>
<td>42,800</td>
</tr>
</tbody>
</table>

Source: Census 2000
Figure 8

Gross Rent as a Percentage of Household Income

Table 18 and Figure 9 present information on gross rent paid by occupants living in rental units. It would be noticed that twenty nine percent of occupants pay rent less than $500, thirty five percent of occupants pay as rent between $500 and $749 and thirty six percent of occupants pay as rent more than $750.

Table 18

Gross rent paid by occupants of rental units

<table>
<thead>
<tr>
<th>Gross Rent</th>
<th>No. of Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $200</td>
<td>10,583</td>
</tr>
<tr>
<td>$200 - $299</td>
<td>6,772</td>
</tr>
<tr>
<td>$300 - $499</td>
<td>25,205</td>
</tr>
<tr>
<td>$500 - $749</td>
<td>48,441</td>
</tr>
<tr>
<td>$750 - $999</td>
<td>28,104</td>
</tr>
<tr>
<td>$1,000 - $1,499</td>
<td>16,202</td>
</tr>
<tr>
<td>$1,500 or more</td>
<td>8,987</td>
</tr>
</tbody>
</table>

Source: Census 2000
Available statistics indicate that fifty four percent of renters earn less than $41,047, the median household income for the District. This high percentage is an indication of the lack of affordable permanent housing units for people with low to moderate incomes. When we juxtapose high rental rates with low income levels of renters, the hardships faced by this population becomes evident. Table 19 and Figure 10 present data on the income categories of renters.

### Table 19

<table>
<thead>
<tr>
<th>Income Category</th>
<th>No. of Rental Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $9,999</td>
<td>31,672</td>
</tr>
<tr>
<td>$10,000 - $19,999</td>
<td>21,757</td>
</tr>
<tr>
<td>$20,000 - $29,999</td>
<td>22,470</td>
</tr>
<tr>
<td>$30,000 - $39,999</td>
<td>19,597</td>
</tr>
<tr>
<td>$40,000 - $49,999</td>
<td>13,007</td>
</tr>
<tr>
<td>$50,000 - $59,999</td>
<td>10,033</td>
</tr>
<tr>
<td>$60,000 - $99,999</td>
<td>18,590</td>
</tr>
<tr>
<td>$100,000 or more</td>
<td>9,978</td>
</tr>
</tbody>
</table>

Source: SOCDS Census Data: Output for Washington, DC.
http://socds.huduser.org/scripts/odbic.exe/housing.htm
**Figure 10**

**Income Category of Renters**

![Pie chart showing income distribution among renters. The percentages are as follows: 30% less than $9,999, 30% $10,000 - $29,999, 22% $30,000 - $49,999, 19% $50,000 - $99,999, 7% $100,000 or more.]

**Income of Households Living with Conditions**

The question of housing availability is not only one of affordability but also one of quality of housing. As Table 20 indicates, thirty four percent of the houses were constructed before 1939 and about seventy eight percent of the houses have been constructed before 1979.

**Table 20**

**Year housing units built**

<table>
<thead>
<tr>
<th>Year Built</th>
<th>Number of Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>274,845</td>
</tr>
<tr>
<td>1999 to 2000</td>
<td>1,160</td>
</tr>
<tr>
<td>1995 to 1998</td>
<td>2,649</td>
</tr>
<tr>
<td>1990 to 1994</td>
<td>3,437</td>
</tr>
<tr>
<td>1980 to 1989</td>
<td>13,695</td>
</tr>
<tr>
<td>1970 to 1979</td>
<td>23,859</td>
</tr>
<tr>
<td>1960 to 1969</td>
<td>42,122</td>
</tr>
<tr>
<td>1950 to 1959</td>
<td>46,785</td>
</tr>
<tr>
<td>1940 to 1949</td>
<td>46,082</td>
</tr>
<tr>
<td>1939 or earlier</td>
<td>95,056</td>
</tr>
</tbody>
</table>


Many old houses have undergone renovations, but some have not. These houses suffer from many conditions. Housing “with conditions” is defined as a household with at least one of the following housing conditions: lacking complete plumbing facilities, lacking complete kitchen facilities, more than 1.01 persons per room, selected monthly owner costs greater than thirty percent of household income (1999), or gross rent as a percentage of household income of greater than thirty percent. According to census data, 2,473 occupied housing units use no fuel for heating their houses, 3,766 units lack complete plumbing facilities and 3,574 units lack complete kitchen facilities. Most of the
households living in these units are low-income: about thirty three percent of households living in housing with conditions have income less that $9,999 and another thirty seven percent earn between $10,000 and $24,000. An alarming seventy percent of households living in rental housing units live in units that either lack facilities (plumbing, heating or kitchens) or pay over thirty percent of their income as rent. (See Table 21 and Figure 11).

Table 21

Income of households living in rentals “With Conditions”

<table>
<thead>
<tr>
<th>Income</th>
<th>Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>63,083</td>
</tr>
<tr>
<td>Less than $9,999</td>
<td>20,948</td>
</tr>
<tr>
<td>$10,000 - $24,999</td>
<td>22,968</td>
</tr>
<tr>
<td>$25,000 - $39,999</td>
<td>10,374</td>
</tr>
<tr>
<td>$40,000 - $59,999</td>
<td>4,897</td>
</tr>
<tr>
<td>$60,000 - $99,999</td>
<td>2,712</td>
</tr>
<tr>
<td>$100,000 or more</td>
<td>1,185</td>
</tr>
</tbody>
</table>

Source: SOCDS data: Output for Washington, DC

Figure 11

Income of Households Living in Rentals “With Conditions”

Homelessness in the District of Columbia

The 2005 Consolidated Plan of the District of Columbia provides the following data on homelessness in the District:

- An estimated 15,200 to 17,340 (2.7 to 3 percent) of District’s population experienced homelessness in 2002, the latest year for which data is available.
- Shelter provided by the both the public and private sector Continuum of Care indicates that 13.2 to 15 percent of the District’s poor experienced homelessness
over the course of a year; 1 in 8 of District residents living in poverty was homeless or living within a homeless Continuum of Care facility during a twelve month period.

- The number of persons living in the streets at any point in time has fallen from an estimated 1,800 persons in 1993 to an estimated 500 persons in 2003.
- The number of homeless men served by public Continuum of Care programs rose 9 percent between 2001 and 2002, while the number of homeless women rose by 22 percent in the same period.
- The annual demand from families seeking shelter fell from 1,406 in 1996 to 962 in 1999. However, the demand increased 172 percent between 1999 and 2002, from 962 in 1999, to 1,276 in 2000, to 2,278 in 2001, to 2,613 in 2002.

Figure 12 is a graphical presentation of the growth in demand for family shelter between the years 1996 and 2002.

**Figure 12**

*Growth in the Demand for Family Shelter*

The homeless population in the District of Columbia comprises many subpopulations with disabilities and special needs. The point-in-time survey of homeless population conducted on January 22, 2003 has been used to estimate the percentages of individuals and persons in families who are homeless as presented in Table 22.
Table 22

Homeless individuals and persons in families in the District of Columbia

<table>
<thead>
<tr>
<th>Subpopulations of Homeless</th>
<th>Individuals (%)</th>
<th>Persons in Families (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic substance abusers (CSA)</td>
<td>36</td>
<td>28</td>
</tr>
<tr>
<td>Seriously mentally ill (SMI)</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Dually diagnosed (CSA/SMI)</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Veterans</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>Persons living with AIDS</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Domestic violence victims</td>
<td>19</td>
<td>55</td>
</tr>
<tr>
<td>Unaccompanied youth (16-21 years of age)</td>
<td>2.6</td>
<td>Na</td>
</tr>
<tr>
<td>African American</td>
<td>80</td>
<td>98</td>
</tr>
<tr>
<td>White</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Latino</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>


The District of Columbia has about 9,700 people who are either homeless or living in unstable housing conditions while 8,400 beds are available in the form of shelters and transitional housing to the homeless on any given day. All homeless programs offering shelter, transitional housing or permanent supportive housing serve over 13,000 persons annually, according to the Community Partnership for the Prevention of Homelessness’s ‘2002 Report to the Community’.43

The District’s homeless continuum of care comprises emergency shelters, transitional housing and permanent supportive housing built to serve formerly homeless and disabled persons. Homelessness continues to afflict District citizens at a rate of almost twice that of other large urban areas.44 The District’s homeless continuum of care has about 8,026 beds available on any given day.45 According to The Community Partnership, there are an estimated total of 8,480 who are literally homeless (6,840) or formerly homeless (1,640). Of the 6,840 who are literally homeless, 5,418 persons live under a roof, but without permanent housing (3,396 in emergency shelters and 2,049 in transitional housing facilities) and 1,422 persons are in need of but not in shelter or adequate housing (496 adults living in the streets and 926 persons in families that are precariously housed and seeking shelter).46

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44 Ibid. Pp: 15
46 Ibid.
The National Alliance to End Homelessness\(^{47}\) in their report ‘How to End Homelessness in Ten Years’ recommends the adoption of different housing strategies for different subpopulations of homeless. They divide the homeless into three subpopulations – chronically homeless, episodically homeless and transitionally homeless. The strategy recommended by the National Alliance for each of these three subpopulations is discussed below.

**Chronically homeless people:** This subpopulation typically lives in shelter systems. According to the Community Partnership nearly 3,400 homeless live in emergency shelters in the D.C. Since few people in this chronic category are likely to ever generate significant earnings through wages (though they may have some income from public benefits), they will require long-term subsidization of both housing and services because of their disabilities. Permanent supportive housing – housing with appropriate and available services and supports --- is highly successful in stabilizing this population.

**Episodically Homeless People:** This group of people uses shelter repeatedly. This group of people frequently interacts with other costly public systems such as prisons and hospitals; they have a high public cost when housed in shelters. They are frequently substance abusers. Experts agree that this group requires a flexible strategy that addresses both their housing needs and their need for treatment. When they are in treatment, clean and sober, supportive housing may work well. In other cases, other housing options may have to be found. Many episodically homeless people are unwilling to receive treatment for addiction, and housing that does not require sobriety (called ‘low demand’ housing) may have to be found for them. This type of housing recognizes the problem and makes services available.

**Transitionally Homeless:** The transitionally homeless are those who have relatively short stays in the homeless assistance. They have had some kind of housing crisis that has led to homelessness. But they will soon find another and house themselves. The real cause of the problem here is shortage of affordable housing. The best way to help this group is to facilitate their accommodation for a short while and help them find permanent housing through effective housing and case management services.

**Strategy to reduce homelessness in the District of Columbia**

The District of Columbia government has identified the following as priority needs in the housing sector:\(^{48}\)

- Increase opportunity for homeownership;
- Preserve and improve existing homeownership by assisting residents with rehabilitation;

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\(^{47}\) The National Alliance to End Homelessness. A Plan: Not a Dream. How to End Homelessness in Ten Years. Available at: [www.endhomelessness.org/pub/tenyear/10yearplan.pdf](http://www.endhomelessness.org/pub/tenyear/10yearplan.pdf)

• Increase available affordable and ownership units by funding rehabilitation of the District’s aging housing stock;
• Increase emphasis on funding for housing units to meet needs of special needs populations, seniors and families;
• Encourage new housing development through construction assistance;
• Preserve affordable housing through intervention, training and housing counseling for project-based tenants;
• Support prevention of homelessness and provide services for the homeless.

The city’s homeless and special need housing efforts focus on:

• Continuing the development of the D.C. Initiative for the Homeless created through public-private partnership.
• Providing transitional housing for persons with special needs such as mental health, substance abuse, HIV/AIDS.
• Support to develop permanent housing opportunities including single room occupancy (SRO) housing.
• Increasing the effectiveness and efficiency of housing resource utilization through improving the coordination of public and private sources of financing.
• Continuing the cooperative efforts between the HAA and the D.C. care consortium to expand housing opportunities for PLWHA and their families.
• Integrating special needs populations into neighborhoods on a citywide basis.

The District government’s strategy for helping low-income families from becoming homeless focuses on prevention and outreach. Under ‘prevention’, the following services are offered:

• Rent and utilities assistance
• Legal assistance to prevent homelessness
• Interim disability assistance that provides monthly financial assistance to the disabled pending federal SSI and SSDI approval.
• Community-based prevention efforts
• Crisis case management

The outreach services comprise the following activities:

• Drop-in centers, free kitchens, food pantries, and free medical services
• UPO Shelter Hotline provide vans to transport the needy to shelters
• Outreach to veterans. Under this head three services are offered to the vets: finding shelters for the homeless, finding permanent employment, and medical care.
• Outreach to mentally ill. In collaboration with the Department of Mental Health, several outreach services are provided to the seriously mentally ill.
• Outreach to substance abusers. The D.C. department of Health/Addiction Prevention and Recovery program (APRA) provides prevention education,
prevention case management, infectious disease screening, and medical detoxification.

- Outreach to persons living with HIV/AIDS: Several community-based organizations provide prevention education, assistance with housing to at-risk populations, HIV counseling and case management, medical case management and medical care.
- Outreach to homeless youth. Children orphaned by HIV/AIDS, runaway youth, and other homeless youth are provided shelters, case management services, and education services.

The District’s Housing Act of 2002 promotes the city’s three principal housing goals:

- Protect existing affordable housing and prevent displacement;
- Convert vacant and dilapidated buildings into new homes; and,
- Promote new housing for people of all incomes.

Toward the realization of the above goals, the Act includes several provisions. These include:

- Housing Preservation legislation to make it easier for the city, non-profits developers, and other tenant-supported buyers to purchase and preserve federally-assisted rental housing.
- Circuit breaker legislation to cap increases in property taxes for low-income, long-term homeowners at 5 percent.
- Historic Housing Tax Credit legislation will help low- and middle-income families to repair and restore historic homes at reduced costs.
- Housing Production Trust Fund legislation and Tax Abatements for New Residential Development legislation will provide additional resources for construction of new houses and rehabilitation.

The District of Columbia has developed a strategy to assist homeless persons make the transition to permanent housing and independent living. The main components of the strategy include:

1. Creation of supportive housing to replace emergency shelters for the chronically homeless. Data from district’s emergency shelters show that about 50 percent of shelter bed nights are utilized as year-round housing by the 10 percent of the chronically homeless. Housing these persons with appropriate supportive houses would allow the District to downsize the emergency shelter system, thereby releasing funds that could be utilized for strengthening permanent housing.
2. Creation of 6000 units of affordable housing over the next ten years through collaborations between the District and institutional funders. This collaboration is expected to produce 3,000 SRO units for individuals, and 3,000 units for low-

income families. Of the 3,000 SRO units, 2,000 will be service-enriched supportive housing for the estimated 1,200 chronically homeless and the rest 800 units will be for the episodically homeless. The remaining 1,000 SRO units are intended for the extremely low-income, non-disabled homeless.

3. **Full integration of mainstream public systems and funding.** The establishment of an Interagency Council (legislation before the City Council) to coordinate and integrate mainstream city and federal services for the homeless.

The D.C. government released its housing strategy in December 2004. The vision of this plan is ‘to improve the quality of life for all residents of the District of Columbia by preventing and ending homelessness within ten years’’. The two major goals of this plan are: substantial production of affordable and supportive housing; and, new institutional strategies to prevent homelessness. The policy objectives highlighted in this document are:

- A greater focus on preventing homelessness
- Promoting permanent housing through creating affordable housing.
- Offer of ‘Housing first’ (moving away from the reliance on shelters) and ‘housing plus’ (affordable housing with support services necessary to maintain housing services) for the chronically homeless families and single adults with disabilities and long history of homelessness.
- Housing people with special needs - families with children, youth, the elderly
- Moving away from a crisis-based approach largely made up of emergency beds to a continuum of care system.

By putting forward a clear vision and action plan for the homeless, this plan proposes to bring together the stakeholders - government, business, faith- and community-based organizations, and communities - whose joint partnership is vital to address the pressing issue of homelessness. The plan projects the creation of a new ‘system of community care’ that will shelter an estimated 18,960 residents or 17 percent of all persons who are living in poverty in the District.

The strategy of the D.C. government housing continuum of care may please be seen at Appendix 1.

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51 A housing first approach rests on two central premises: (1) re-housing should be the central goal of work with people experiencing homelessness; and (2) providing housing assistance and follow-up case management services after a or individual is housed can significantly reduce the time the people spend in homelessness. Case management ensures individuals and families have a source of income through employment and/or public benefits, identifies service needs before they move into public housing, and works with them after the move into permanent housing to help solve problems that may arise that threaten their tenancy including difficulties sustaining housing or interacting with the landlord and to connect families with community based services to meet long-term support service needs.
The latest strategic plan of the D.C. government calls for the production of 6,000 new affordable housing units to be distributed among the various sections of the population. The proposed distribution of the 6,000 housing units is presented in Table 23.

**Table 23**

**Distribution of proposed new affordable housing units in the District of Columbia**

<table>
<thead>
<tr>
<th>Household type</th>
<th>Units to be made affordable</th>
<th>Affordable units to be made ‘supportive housing’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronically homeless adults, including elderly</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Working poor and elderly adults</td>
<td>800</td>
<td>0</td>
</tr>
<tr>
<td>Unaccompanied youth under 21 years of age</td>
<td>200</td>
<td>0</td>
</tr>
<tr>
<td>Families with children</td>
<td>3,000</td>
<td>500</td>
</tr>
<tr>
<td>Total</td>
<td>6,000</td>
<td>2,500</td>
</tr>
</tbody>
</table>


The overall direction of the plan to end homelessness is encouraging. The strategic plan correctly focuses on increasing efforts to prevent homelessness. The proposal to create a D.C. Interagency Council on Homelessness is an important step in the direction of coordinating the activities of various agencies that in one way or the other work toward preventing homelessness in the District. The proposal to help homeless people enter the continuum of care is also a step in the right direction. Finally, the appeal to “unite voices in appealing to the federal government both to maintain and to increase subsidies for affordable housing”\(^\text{52}\) is most timely and appropriate.

The strategy proposes a system of neighborhood-based continua of care for the next ten years that will alter the composition of housing for the homeless. The present and proposed continuum of care systems are presented in Tables 24 and 25.

---

Table 24
The Continuum of care system in D.C. (Publicly-supported Beds)

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>2004</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beds</td>
<td>%</td>
<td>Beds</td>
<td>%</td>
</tr>
<tr>
<td>Emergency 12-24 hours</td>
<td>3,331</td>
<td>75</td>
<td>2,891</td>
<td>40</td>
</tr>
<tr>
<td>Transitional</td>
<td>744</td>
<td>17</td>
<td>1,808</td>
<td>25</td>
</tr>
<tr>
<td>Permanent Supportive</td>
<td>381</td>
<td>9</td>
<td>2,543</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>4,457</td>
<td>100</td>
<td>7,241</td>
<td>100</td>
</tr>
<tr>
<td>Overnight 12-hour shelter*</td>
<td>1,144</td>
<td>26</td>
<td>1,171</td>
<td>16</td>
</tr>
</tbody>
</table>

* A subset of emergency shelter beds
Source: Homeless No More

Table 25
The proposed continuum of care system in D.C. (By 2014)

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beds</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Easy-access. Rapid exit HACs*</td>
<td>1,709</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Transitional housing</td>
<td>1,808</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Permanent ‘Housing Plus’ (inside the community care system)</td>
<td>6,193</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9,710</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Permanent affordable housing (beds) (outside the community care system)</td>
<td>9,250</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

π: These beds serve about 13,800 annually
$: 1,000 affordable units for adults and youth, and 2,500 units (8,250 beds) for families
*: HAC = Housing Assistance Centers
Source: Homeless No More

A brief summary of the affordable housing initiative of San Jose, California that won the HUD secretary’s Planning Award for the year 2005 may be seen at Appendix 2. The summary showcases the planning process undertaken by the city for creation of 6,080 affordable housing units in five years and its successful implementation within that period. Through an effective combination of new developments and acquisition/rehabilitation strategies the city was able to exceed its target in the stated time horizon. Other strategies that worked well for the city was the leveraging of $3.70 of outside funding for every $1.00 of city funds effective partnerships.
CHAPTER V
HOPWA PROGRAM IMPLEMENTATION IN THE DISTRICT OF COLUMBIA

The early AIDS housing programs, nationally, were started in the mid 1980s by foundations, faith-based institutions, local corporations and individuals who felt the need to respond to a health crisis that was devastating their communities, had yet to receive assistance at the federal level. Many of these programs were small-four-to-eight-bed group homes providing independent housing, or small facilities providing hospice care in existing buildings53. These facilities attended to the psychosocial needs of their residents and focused on providing end of life care. Those in need of medical intervention were sent to hospitals.

By the 1990s, AIDS was an established reality in the U.S. due to the large number of people affected. The nature of the disease called for some level of support services in the form of case management, access to medical services and housing. As a result, the need for appropriate healthcare, housing, and support services increased. Government funding and diverse private funding sources helped AIDS housing projects become mainstream affordable and supportive housing providers with the participation of public housing authorities and local governments. The 1990s also saw many changes in the types of housing for people living with HIV/AIDS and a significant growth in the numbers of units available. A study by Vanderbilt University in 1999 found that nearly 28,000 units of housing in the U.S. are dedicated for PLWHA. Most of these units (17,190), the study found, were provided through vouchers.54

Funding for HIV/AIDS Housing and Services

Homeless individuals with HIV/AIDS depend almost entirely on publicly-funded housing to assist them in stabilizing their living situations and health. Such assistance includes federal funds provided through HUD, including Housing Opportunities for People with AIDS (HOPWA), rental subsidy vouchers through Section 8, and the McKinney/Homeless Assistance Grants (HAG). Some communities also combine federal HOPWA funds with CARE Title I and local general funds to expand the availability of affordable housing. Since 1992, when HOPWA program was first authorized, the federal government has made available over $1.27 billion in HOPWA funds to support community efforts to develop and administer HIV/AIDS housing and support service programs. In 1992 there were 27 eligible metropolitan statistical areas and 11 states eligible to receive formula allocations of $42.9 million in HOPWA funds. By 1995, HOPWA funding increased to $153.9 million and the number of grantees increased to 43 eligible metropolitan areas and 23 states.

Since the early 1980's, HUD budgets have steadily fallen further behind the levels needed to address the rapidly increasing demand for affordable housing. Today, HUD is only one

of a large number of sources of financing for affordable housing, along with banks, investors, the Federal Home Loan Bank, public agencies and foundations, among others.

Unlike their predecessors, today's housing developers - and particularly nonprofit sponsors - must often piece together as many as ten or twelve different funding sources to make a development feasible. Nonprofits have become extremely versatile at identifying and melding all of the financing pieces required.

A typical nonprofit developer might combine funds from public agencies, a corporate tax credit investor, a loan supported by Section 8 rent subsidies, and private donations in order to build supportive housing.\textsuperscript{55} Each source requires a competitive funding application, approval process and recorded legal documents, all of which added to the complexity and the cost of the development.

**Housing Continuum and Housing Options for People Living With HIV/AIDS**

HIV/AIDS housing needs fall into an overall community-wide housing continuum\textsuperscript{56} that divides housing resources into the following categories:

Emergency → Transitional → Permanent → Specialized Care

**a. Emergency Housing Assistance**

Emergency housing assistance is one-time or very short-term assistance provided to address an immediate housing crisis – often for people who are homeless or at imminent risk of becoming homeless. The primary goal of emergency assistance is to solve the immediate housing crisis; the assistance may take one of the following forms:

1. **Emergency rent, mortgage, or utility payments to prevent loss of residence:** This assistance is meant to help households facing a crisis that could result in displacement from their current housing. It is designed to address one-time crises, and not ongoing needs. This can be a cost-effective form of assistance as it is less expensive to keep people in their homes than to find or develop new ones. However, this form of assistance may not result in long-term affordable housing as PLWHA need ongoing financial assistance rather than one-time assistance to remain in their homes.

2. **Hotel or Motel Vouchers:** This is a form of emergency assistance given to households that have no other alternative but to live on the streets or in substandard or inappropriate housing situations. The vouchers may facilitate stays of a week to a month and the providers are billed by the hotels or motels as the rooms are used. This is at best a quick fix short-term solution and does not address the long-term housing problem.


3. **Emergency Shelter:** Emergency shelter is basic, temporary, overnight sleeping accommodation. Stays at emergency shelter are often limited to less than 30 days at a time. Emergency shelter can either be in the form of beds in dormitory style rooms or mattresses on the floor of space that has a different daytime use (church assembly room). Some shelters may provide private rooms for families and meal programs. The main advantage of this form of assistance is that it is a cost-effective way of providing immediate response to housing needs. But it is also problematic in so far as they may require people to go elsewhere during the day; also many privacy issues are involved.

**b. Transitional Housing Assistance**

Transitional housing assistance is for a limited duration, usually up to two years. It is intended to help people transition from a housing crisis into a permanent, stable housing situation. Its goal is to provide temporary housing and services to help households develop the skills needed to find employment that will generate resources for permanent housing. Transitional housing assistance is effective when households are likely to become self-sufficient and transition to permanent housing by the time the assistance ends. Transitional housing assistance includes:

- Assistance with move-in and occupancy needs.
- Tenant-based transitional housing.
- Supportive transitional housing project.

1. **Assistance with Move-in and Occupancy Needs:** Move-in/occupancy needs assistance comprises assistance to households in overcoming one-time challenges of establishing a new residence. Typical assistance includes providing moving expenses, rent deposit, move-in kit (linens, cookware, dishes, flatware, cleaning supplies), furniture, appliances, utility hook-up fees, and basic life skill training. This type of assistance can be in-kind or cash payments.

2. **Tenant-based Transitional Housing Assistance:** This is a tenant-based rental assistance program on a transitional basis usually for a period not longer than two years.

3. **Supportive Transitional Housing:** Supportive transitional housing is temporary housing combined with support services designed to assist homeless families and individuals overcome the problems that led to their homelessness and return to living in permanent, independent housing. The services provided through a transitional program may address substance abuse, mental health, life skills training, education, and family support, and may help establish relationships between the consumers and service providers.

**c. Permanent Housing Assistance**

The goal of permanent housing assistance is to create safe and stable housing opportunities. Permanent housing assistance includes the following:
Support services designed to help people live independently, provided on an ongoing basis.

Tenant-based rental assistance.

Provision of actual housing units through sponsor- or project-based assistance through:
- Lease buy-downs
- Set-asides in larger housing projects
- Scattered-site condominium acquisition
- Group homes/Shared housing
- Independent apartment development projects.

1. Support Services: Support services are most often offered as a complement to a housing situation. In some cases, an array of support services may be needed to stabilize PLWHA and without it they may risk losing their housing. Services generally include case management, home care, counseling, nutrition and meal services, crisis intervention, legal assistance, transportation, day health programs, mental health services, and substance abuse treatment services. These services may be provided by an AIDS service network or through other service providers. While support service provision can help tenants remain in their existing homes, it may be a comparatively expensive option, particularly to people living in widely scattered locations.

2. Tenant-Based Rental Assistance: Tenant-based rental Assistance (TBRA) is ongoing assistance paid to a tenant (or his/her landlord) to cover the difference between the market rents and what the tenant can afford to pay. Tenants find their own units and may continue receiving the rental assistance as long as their income remains below the qualifying income standard. Many TBRA programs are federally subsidized, administered by local public housing authorities, and governed by HUD’s Section 8 regulations (Section 8 subsidy levels set at the difference between HUD’s annually established FMR for the appropriate unit size and 30 percent of the tenant’s household income). Some are funded through HOPWA, or operated by private AIDS service organizations and nonprofit agencies. The TBRA has the advantage that tenants may choose where they live and pay only 30 percent of their income toward rent; the problem is that it does not create new long-term housing resources and is subject to the availability of funds on a regular basis.

3. Shallow Rent or Mortgage Subsidies: Shallow rent or mortgage subsidies provides a small, fixed amount on a monthly basis to help the consumer close any gaps between the rent or mortgage payments. In most cases consumers are close to being able to afford housing costs independently, and just need regularly a small amount of assistance. Mortgage assistance is particularly helpful to those consumers who are homeowners.

4. Set-Asides in Other Housing Projects: In areas where it is not possible to develop new housing units, a good way to secure affordable units is to negotiate
set-asides for PLWHA in projects developed by affordable housing providers. A project based set-aside involves a housing developer or owner dedicating a specified number of units to serve a special needs population for a defined term, up to the life of the project. The AIDS housing provider and property manager establish terms for the set-aside in a legal agreement. These negotiations may include referral agreement or contribution of capital (lease buy-down) or a master lease to help lower rents. The main advantage of this form of assistance is that it helps residents integrate into the community on a long-term basis. But the difficulty in its implementation arises when the need for affordable rental units is so great (as is the case in most metropolitan areas) that housing providers may not be willing to enter into special set-aside agreements.

4. **Lease Buy-Downs:** In a lease buy-down, an AIDS service organization enters into a long-term lease agreement with a property manager, and establishes a rent reserve fund which will pay the difference between the market rent and the amount that the residents can pay. The rent reserve is funded at the outset at a level that will last through the term of the lease. The payment amount is calculated by taking the Net Present Value (NPV) of the difference between the tenant’s rental income stream and the rental income stream required to sustain the unit. The terms of the lease, the discount factor used to determine the NPV, and the basis for the affordable rents are all matters of negotiation between the AIDS housing organization and the housing provider. The main problem with this form of assistance is that developing contractual agreements can be complicated, time consuming and expensive.

5. **Master Leasing:** Master leasing can be used to provide either transitional or permanent housing. Using this strategy, the AIDS housing provider leases units – individually as single family homes, on a floor, or throughout an entire building, and in turn leases them out at an affordable cost to PLWHA. Master leasing is typically for a shorter term than lease buy-downs. While this method can ensure that housing units are secured quickly, the housing providers must make sure that support services are available in the leased locations.

6. **Scattered-Site Acquisition:** Acquiring scattered-site condominiums or single-family homes and leasing these units to PLWHA is a way for AIDS housing organizations to have direct ownership rights over the properties thereby reducing some of the entanglements encountered in the other forms of leasing. The AIDS organizations have to be able to raise capital funding to purchase condominiums or single-family homes.

7. **Group Homes or Other Shared Housing Arrangements:** Group living assistance mainly includes group homes owned by an AIDS housing organization. A group home or other shared housing can either be purchased or leased by the AIDS housing organization. Group living situations work best only when there is sufficient demand for it; empty rooms and beds can make them economically unviable. This form of housing may have limited appeal as it is common
knowledge that PLWHA often prefer independent units over shared accommodation.

8. Independent Apartment Development Projects: Independent apartment projects can be developed by HIV/AIDS housing organizations specifically to meet the permanent housing needs of PLWHA, or to serve a mixed population that includes PLWHA. AIDS housing organizations can function as the developer, owner, manager, and service provider for the units, or they contract out these functions to other experienced organizations. Independent apartment projects work best in communities which have a sufficiently large demand for HIV/AIDS housing units. This requires a long-term commitment to housing operation on the part of housing providers. They may also require ongoing operating subsidy to keep rents affordable for PLWHA.

d. Specialized Care Facilities

Specialized care facilities include short- and long-term housing combined with services designed to assist those people whose medical or behavioral health make independent living impossible. Specialized care facilities range from assisted living to skilled nursing to hospice care. These facilities may either cater to the needs of only PLWHA or all those whose support needs are similar. Specialized care facilities are best suited to communities with large concentration of PLWHA who require higher-end care. Because specialized care requires complex technical skills in both provision of care and business management, and because it is highly regulated, specialized care facilities work best when an experienced specialized care provider partners with the housing provider.

A graphical presentation of the housing continuum for PLWHA in the District of Columbia prepared by the Housing Counseling Services, Inc., the gatekeeper to the D.C. HOPWA program may be seen at Appendix 3.

HOPWA Program Administration

Under the HOPWA program, HUD is required to allocate HOPWA funds based upon certain formula factors. The formula funds are based on AIDS surveillance data of the states as reported to CDC as of March 31st of the immediately preceding fiscal year. The statute requires that HUD allocate 75 percent of the formula amount to the qualifying jurisdictions for areas that have more than 1,500 cumulative cases of AIDS. In FY 2004, there were 117 eligible jurisdictions, including 79 cities and 38 states. The rest of the HOPWA formula amount (25 percent) is allocated among the qualifying cities, on behalf of the metropolitan statistical areas with more that 500,000 population where the per capita incidence of AIDS for the year preceding the fiscal year of the appropriation is higher than the average for all metropolitan statistical areas with more than 500,000 population. In 2004 this part of the formula funds were allocated to 24 cities.

The District of Columbia Department of Health HIV/AIDS Administration (HAA) is the HOPWA Formula Regional Grantee for the Washington D.C. Eligible Metropolitan
Statistical Area (EMSA) that includes, apart from the District of Columbia, Suburban Maryland, Suburban Virginia, and Suburban West Virginia. The EMSA contains racially and ethnically diverse population as well as inner cities and rural areas. The HOPWA funds are distributed among these jurisdictions in the following ratio:

- D.C – 56.6 percent;
- Maryland – 24.8 percent;
- Virginia – 17.6 percent; and
- West Virginia – 1 percent.

The District HIV/AIDS Administration is under the DC Department of Health’s Health Promotion cluster. The HAA includes these divisions: Administration, Operations, Finance, Data and Evaluation, Grants and Contract Management, Health and Support Services, Prevention, and Communication. The Grants and Contract Management Division is responsible for monitoring HOPWA program, while the HIV/AIDS Housing Coordinator in the Health and Support Services Division provides programmatic oversight for all HOPWA providers in D.C. All District agencies responsible for providing housing to persons with special needs, such as the Commission on Mental Health, Addiction Prevention and Recovery Administration, D.C. Housing Authority, the Community Partnership for the Prevention of Homelessness, and the HIV/AIDS Administration, are coming together and sharing information with a view to increasing the effectiveness and efficiency of HIV/AIDS service delivery system in the District. Currently the HAA has also established a grant agreement with the D.C. Housing Authority to provide Housing Quality Standards inspections for all HOPWA funded housing units. This collaborative effort is expected to ensure that clients have quality housing.

The HAA Housing Program provides housing support services and discharge planning activities. To acquire additional Shelter Plus Care (S+C) funding, the Housing Division participates in the Homeless Continuum of Care application process administered by The Community Partnership. The HAA-funded housing infrastructure is supported by $1.2 million S+C dollars and $1.455 million in D.C. appropriated dollars. However, the HAA does not have direct access to CDBG, HOME, and ESG grants.

As the project sponsor for the District of Columbia, the HAA has the mission “to prevent the spread of HIV transmission and to ensure the management, oversight, planning, and coordination of HIV/AIDS services and programs in the District of Columbia, in collaboration with other government and community organizations.” HAA also administers the Ryan White Title I Program for the DC EMSA, the District’s Ryan White Title II, AIDS Drugs Assistance Program (ADAP), and Centers for Disease Control (CDC) funding for HIV/AIDS prevention and surveillance activities. HAA is also the local administrative agency for the HOPWA program in the District of Columbia.

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HAA sub-grants to project sponsors in suburban jurisdictions which in turn sub-contract with local service providers. The HAA works in partnership with a number of community-based organizations in the effort to provide housing assistance and supportive services to PLWHA in the District. In the District of Columbia, service providers are selected through a competitive grant Request for Application (RFA) process. Some of the District’s HOPWA community partners include:\textsuperscript{58}

\textbf{The Gatekeeper}
- Housing Counseling Services, Inc

\textbf{Tenant-based Rental Housing Program}
- Building Futures
- Community Connections
- Community Family Life Services
- DC CARE Consortium
- Different Avenues
- Efforts, Inc.
- Greater Washington Urban League
- Healthy DC Foundation
- Hills Community
- Homes for Hope
- Home Survey
- Housing Counseling Services, Inc.
- La Clinica del Pueblo
- Our Children, Inc.
- Our Place DC
- Perry School Community Service Center
- TERRIFIC, Inc.
- Transgender Health Empowerment
- United Planning Organization

\textbf{Facility-based Housing with Supportive Services}
- Coates and Lane Foundation
- Damien Ministries
- Joseph’s House
- Miriam’s House
- RIGHT, Inc.
- Whitman Walker Clinic
- Northwest Church Family Network

\textsuperscript{58} Ibid.
Facility-based Emergency Housing with Supportive Services

- Miracle hands
- Regional Addiction Prevention (RAP), Inc.

These service providers are located in all the eight wards of DC, though not evenly distributed. The distribution of these service providers among the wards is presented in Table 26.

Table 26

<table>
<thead>
<tr>
<th>Ward 1</th>
<th>Ward 2</th>
<th>Ward 3</th>
<th>Ward 4</th>
<th>Ward 5</th>
<th>Ward 6</th>
<th>Ward 7</th>
<th>Ward 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Service Providers</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>No. of AIDS cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1361</td>
<td>1195</td>
<td>189</td>
<td>786</td>
<td>1007</td>
<td>1088</td>
<td>726</td>
<td>809</td>
</tr>
<tr>
<td>No. of AIDS cases per Service Provider Organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>226</td>
<td>597</td>
<td>189</td>
<td>262</td>
<td>112</td>
<td>363</td>
<td>726</td>
<td>809</td>
</tr>
</tbody>
</table>

Source: HIV/AIDS Administration

The policy and priorities guiding the planning and implementation of HOPWA services in the District of Columbia are:59

- Implement EMSA’s Strategic Spending Plan 2000-2004;
- Establish a diversified housing continuum of care through program development and access to non-AIDS specific housing resources;
- Increase participation, collaboration and leveraging with Ryan White funds, local DHCD Block Grant, mental health, and substance abuse programs;
- Improve reporting and client tracking;
- Empower clients toward self sufficiency through vocational and/or other rehabilitation;
- Provide housing information and referral;
- Direct all major rehabilitation, repair and acquisition projects to target local CDBG, HOME, and ESG grants for funding (HOPWA funding will be used on a small scale and/or as the funding of last resort for these purposes);
- Establish housing plans and methods to transition clients who are willing and able to move into assisted housing within a 30-month period.

• Establish select housing demonstration programs for targeted groups such as women;
• Develop a strategic housing plan for the EMSA; and
• Provide housing mediation services for tenants and landlords.

The HOPWA formula allocations for the Washington, D.C. eligible metropolitan area has been growing over time. The formula allocation is given in Table 27.

Table 27

HOPWA Formula Allocation: Washington, DC Eligible Metropolitan Area

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocations ($ `000)</td>
<td>5,747</td>
<td>6,475</td>
<td>6,335</td>
<td>8,721</td>
<td>10,451</td>
<td>9,862</td>
<td>11,802</td>
<td>10,535(est)</td>
</tr>
</tbody>
</table>

Source: CAPER (various years)

Figure 13

HOPWA Formula Allocation: Washington, DC Eligible Metropolitan Area

Table 28 presents HOPWA program accomplishments for the D.C. for the period 2002-2003.
### Table 28

**HOPWA program accomplishment**
**(2002-2003)**

<table>
<thead>
<tr>
<th>Type of Unit</th>
<th>No. of Units</th>
<th>HOPWA Funds ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rental assistance</td>
<td>639</td>
<td>4,690,506</td>
</tr>
<tr>
<td>Short-term or emergency housing payments</td>
<td>858</td>
<td>1,731,216</td>
</tr>
<tr>
<td>Units in facilities supported with operating costs</td>
<td>12</td>
<td>35,353</td>
</tr>
<tr>
<td>Units in facilities that were developed with capital costs and opened and served clients</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Units in facilities that are being developed with capital costs but not yet opened</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>1509</td>
<td>6,457,075</td>
</tr>
<tr>
<td>Deduction for units reported in more than one category</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Housing subtotal</td>
<td>1503</td>
<td>6,457,075</td>
</tr>
<tr>
<td>Resource identification/Technical assistance</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Supportive services</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Housing placement assistance</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>a. Housing information services</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>b. permanent housing placement services</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Total HOPWA funds expended</td>
<td></td>
<td>6,457,075</td>
</tr>
</tbody>
</table>

Source: U.S. Department of Housing and Urban Development.
Table 29 presents demographic break up of HOPWA beneficiaries.

### Table 29

**Race, Age and Income of HOPWA Beneficiaries**

<table>
<thead>
<tr>
<th>Race</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>334</td>
<td>16.11</td>
</tr>
<tr>
<td>Black</td>
<td>1558</td>
<td>75.16</td>
</tr>
<tr>
<td>Hispanic</td>
<td>173</td>
<td>8.35</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>5</td>
<td>0.24</td>
</tr>
<tr>
<td>American Indian</td>
<td>3</td>
<td>1.14</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 and under</td>
<td>266</td>
<td>13.53</td>
</tr>
<tr>
<td>18-30 years</td>
<td>102</td>
<td>5.19</td>
</tr>
<tr>
<td>31-50 years</td>
<td>686</td>
<td>34.91</td>
</tr>
<tr>
<td>51 and over</td>
<td>82</td>
<td>4.17</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 and under</td>
<td>206</td>
<td>10.48</td>
</tr>
<tr>
<td>18-30 years</td>
<td>129</td>
<td>6.56</td>
</tr>
<tr>
<td>31-50 years</td>
<td>443</td>
<td>22.54</td>
</tr>
<tr>
<td>51 and over</td>
<td>51</td>
<td>2.59</td>
</tr>
<tr>
<td>Monthly Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0-250</td>
<td>328</td>
<td>24.26</td>
</tr>
<tr>
<td>$251-500</td>
<td>370</td>
<td>27.37</td>
</tr>
<tr>
<td>$501-1000</td>
<td>483</td>
<td>35.72</td>
</tr>
<tr>
<td>$1001-1500</td>
<td>131</td>
<td>9.69</td>
</tr>
<tr>
<td>$1501-2000</td>
<td>18</td>
<td>1.33</td>
</tr>
<tr>
<td>$2000 and above</td>
<td>22</td>
<td>1.63</td>
</tr>
</tbody>
</table>

Source: HOPWA Beneficiary Summary Grantee Report. 2001 Baseline Non-Admin Activities. HUD.

Table 30 presents break up of HOPWA funds utilization for supportive services in the District of Columbia for the period ending December 2002.
Table 30

Supportive Services Funded by HOPWA Funds

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Amount ($)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>17,338</td>
<td>1.94</td>
</tr>
<tr>
<td>Case management</td>
<td>479,693</td>
<td>53.67</td>
</tr>
<tr>
<td>Life management</td>
<td>4,908</td>
<td>0.55</td>
</tr>
<tr>
<td>Nutritional services/meals</td>
<td>5,950</td>
<td>0.67</td>
</tr>
<tr>
<td>Adult day care and personal assistance</td>
<td>67,581</td>
<td>7.56</td>
</tr>
<tr>
<td>Child care and other children’s services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employment assistance</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol and drug abuse services</td>
<td>4,085</td>
<td>0.46</td>
</tr>
<tr>
<td>Mental health services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health/Medical/Intensive care services</td>
<td>1,290</td>
<td>0.14</td>
</tr>
<tr>
<td>Permanent housing placement</td>
<td>5,805</td>
<td>0.65</td>
</tr>
<tr>
<td>Other supportive services</td>
<td>307,107</td>
<td>34.36</td>
</tr>
<tr>
<td>Total</td>
<td>893,757</td>
<td>100</td>
</tr>
</tbody>
</table>


The recent living situation of the beneficiaries, as of 2002, shows that only sixty seven percent of the beneficiaries had some form of stable housing [living with relatives/friends (27.7 percent), rental housing (37.3 percent) and own house (2.1 percent)]. About 11.7 percent lived in transition housing/emergency shelters and four (4) percent lived in some form of medical facility and another four (4) percent were homeless. The living situation of HOPWA beneficiaries is presented in Table 31.

Table 31

Recent Living Situation of HOPWA Beneficiaries

<table>
<thead>
<tr>
<th>Living Situation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless/Street</td>
<td>3.92</td>
</tr>
<tr>
<td>Transition housing</td>
<td>5.30</td>
</tr>
<tr>
<td>Emergency shelters</td>
<td>6.39</td>
</tr>
<tr>
<td>Psychiatric facility</td>
<td>0.29</td>
</tr>
<tr>
<td>Substance abuse treatment facility</td>
<td>2.18</td>
</tr>
<tr>
<td>Hospital/medical facility</td>
<td>1.67</td>
</tr>
<tr>
<td>Jail/prison</td>
<td>0.87</td>
</tr>
<tr>
<td>Domestic violence situation</td>
<td>0.36</td>
</tr>
<tr>
<td>Living with relatives/friends</td>
<td>27.72</td>
</tr>
<tr>
<td>Rental housing</td>
<td>37.30</td>
</tr>
<tr>
<td>Participant owned housing</td>
<td>2.18</td>
</tr>
<tr>
<td>Other situation</td>
<td>11.83</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: U.S. Department of Housing and Urban Development
Tables 32 and 33 present a break down housing assistance among individuals and families and housing assistance by type of housing using HOPWA funds.

**Table 32**
Housing Assistance with HOPWA funds

<table>
<thead>
<tr>
<th>Persons assisted with housing assistance</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons (adults and children) with HIV/AIDS</td>
<td>1406</td>
<td>(61.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons in family units</td>
<td>898</td>
<td>(32%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2304</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Families assisted with housing assistance | 604    |        |        |        |        |       |     |

**Persons assisted with supportive services**

| Persons (adults and children) with HIV/AIDS | 156    |        |        |        |        |       |     |
| Persons in family units                     | 0      |        |        |        |        |       |     |
| **Total**                                   | 156    |        |        |        |        |       |     |


**Table 33**
Housing assistance by type of housing

<table>
<thead>
<tr>
<th>Units by number of bedrooms</th>
<th>SRO</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility-Based Housing Assistance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-term facility</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>12</td>
<td>10.1</td>
</tr>
<tr>
<td>SRO dwelling</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community residence</td>
<td>28</td>
<td>20</td>
<td>7</td>
<td>18</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>77</td>
<td>64.7</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>30</td>
<td>25.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28</td>
<td>20</td>
<td>23</td>
<td>34</td>
<td>2</td>
<td>13</td>
<td>0</td>
<td>119</td>
<td>100</td>
</tr>
</tbody>
</table>

| **Scattered-Site Housing Assistance** |     |   |   |   |   |   |   |       |       |
| Tenant-based rental assistance  | 22  | 234| 719| 396| 200| 41 | 333| 1945  |       |
| **Percentage share**            | 1.1 | 12.0| 36.9| 20.3| 10.2| 2.1| 17.1| 100   |       |
| Short-term rent, mortgage, utility payment | 39 | 271| 505| 297| 159| 19 | 444| 1734  |       |
| **Percentage share**            | 2.2 | 15.6| 29.1| 17.1| 9.1 | 1.1| 25.6| 100   |       |

Source: HUD

Table 34 presents details of institutions that provide continuum of care housing exclusively to people living with HIV/AIDS in the District of Columbia. Besides these, there are many others who provide continuum of care housing services to PLWHA in addition to others such as substance abusers and those with disabilities.
Table 34

Components of Continuum of Care System for People Living with HIV/AIDS, 2003

<table>
<thead>
<tr>
<th>Provider</th>
<th>Facility</th>
<th>Beneficiary Category</th>
<th>Individuals</th>
<th>Family with Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Shelter</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAP, Inc</td>
<td>Emergency shelter</td>
<td>SMF</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>Transitional Housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>La Clinica del Pueblo</td>
<td>HAA transitional</td>
<td>SMF</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>RAP, Inc</td>
<td>HAA transitional</td>
<td>SMF</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td><strong>Permanent Supportive Housing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building Futures</td>
<td>Daffodil House</td>
<td>FC</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Building Futures</td>
<td>Sunflower House</td>
<td>FC</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Building Futures</td>
<td>Marigold Place</td>
<td>FC</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Building Futures</td>
<td>TCP-S+C Units</td>
<td>FC</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Building Futures</td>
<td>TCP-S+C Units</td>
<td>FC</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Community Connections</td>
<td>1330 G Street, NE</td>
<td>SMF</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>DOH w/Our Children</td>
<td>S+C Units</td>
<td>SMF</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Missionaries of Charity</td>
<td>Gift of Peace</td>
<td>SM</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Joseph’s House</td>
<td>Joseph’s House</td>
<td>SM</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Miriam’s House</td>
<td>Miriam’s House</td>
<td>SF</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>RIGHT, Inc</td>
<td>HAA Permanent</td>
<td>FC</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>RIGHT, Inc</td>
<td>HOPWA Permanent</td>
<td>FC</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>RIGHT, Inc</td>
<td>TCP-S+C Units</td>
<td>FC</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>RIGHT, Inc</td>
<td>TCP-S+C Units</td>
<td>SMF</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>TERRIFIC, Inc</td>
<td>HAA Units</td>
<td>FC</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Whitman Walker Clinic</td>
<td>Schwartz Housing</td>
<td>FC</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Whitman Walker Clinic</td>
<td>Schwartz Housing</td>
<td>SMF</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>117</td>
<td>202</td>
</tr>
</tbody>
</table>

SM = Only single males (over 18 years); SF = Only single females (over 18 years); SMF = Only single males and females (over 18 years) with no children; FC = Families with children.


Housing Gaps Analysis

There has no doubt been a significant increase in publicly-funded housing in the District of Columbia in recent years. According to the Community Partnership “through a combination of increasing and reallocating District funds over that time (1994 to 2002), as well as adding substantial new federal funds won through national competitions, the [housing] system is both larger and more balanced between emergency care and
programs that provide longer-term assistance through transitional and permanent supportive housing. Yet Community Partnership projects an unmet gap of 2,087 beds for individuals and 4,175 beds for persons in families with children.

The housing gaps analysis data has been collected by Community Partnership for the Prevention of Homelessness (TCP) and is used here to estimate the demand and supply gap in housing in the District. The data has been compiled on the basis of information collected from every public and private agency operating homeless programs. The data describes the community’s determination of availability, need and the gap between the two in respect of emergency shelters, transitional housing and permanent supportive housing for the homeless. Table 35 provides information on the demand and supply of housing/beds and the unmet needs.

Table 35

<table>
<thead>
<tr>
<th>Housing Gaps Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gap in the housing/beds for individuals</strong></td>
</tr>
<tr>
<td>Need</td>
</tr>
<tr>
<td>Emergency shelter</td>
</tr>
<tr>
<td>Transitional housing</td>
</tr>
<tr>
<td>Permanent supportive housing</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td><strong>Gap in housing/beds for persons in families with children</strong></td>
</tr>
<tr>
<td>Need</td>
</tr>
<tr>
<td>Emergency shelter</td>
</tr>
<tr>
<td>Transitional housing</td>
</tr>
<tr>
<td>Permanent supportive housing</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
</tr>
</tbody>
</table>


**Needs and Challenges**

An increasing number of people and families in the District need access to information about housing options. This is especially true of people living in poverty, women,

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61 Created as part of the D.C. Initiative involving a partnership between HUD, The District’s Government and numerous nonprofit housing and service providers, The Community Partnership is responsible for administering homeless programs funded by both the District Government and the federal government.
minorities and larger families. The stigma associated with HIV/AIDS makes it difficult to identify housing options particularly when many landlords are not willing to provide housing for individuals and families with HIV/AIDS.

As more people become affected by HIV, and as those with AIDS live longer, housing will become increasingly challenging. More housing coordinators and service providers will be needed to meet the growing challenge. These housing service providers should have adequate resources to face the dual task of identifying housing and reaching out to landlords who can provide adequate and safe housing for PLWHA and their families.

Unless more funding is made available, available and affordable housing will quickly outstrip the demand for housing. As housing availability becomes more and more difficult, the demand for emergency assistance and rental assistance will rise proportionately. It is imperative to assist and support housing service providers to enable them to meet the emerging needs of their clients.

Apart from availability, there is also the question of maintainability. In the next three to five years, as numbers of PLWHA grow due to either fresh infections or to medical advances, the number of seniors living with AIDS will also grow, thereby creating an increasing need to help them maintain their homes. More people will be needing assistance for longer periods of time. Continuous and adequate funding will be necessary to avert a housing crisis among PLWHA. Unless aggressive efforts are made to expand housing options, large number of individuals will be entering the shelter system in order to access basic services.

A special challenge is reaching the homeless. Active outreach to shelters is necessary to identify these individuals and families. Assistance is especially problematic for individuals with multiple diagnoses – with HIV and mental illness or substance abuse or both. Also, as more seniors, women, undocumented immigrants and IDUs need housing services, housing options that reflect their unique needs and circumstances need to be augmented.

**HOPWA Reporting Requirements**

HUD requires each of its federal entitlement grant recipients, including HOPWA, to file an annual Consolidated Annual Performance and Evaluation Report (CAPER). The CAPER must be submitted to HUD within 90 days after the close of the fiscal year. A copy of “HOPWA Formula Grantee Annual Reporting – Measuring Performance Outcomes in the CAPER” may be seen at Appendix 4.

The HOPWA grantees are also expected to submit an “Annual Progress Report – Measuring Performance Outcomes” to HUD. This report provides annual information on the accomplishments of the program in providing housing assistance for low-income persons living with HIV/AIDS and their families. A copy of the report format may be seen at Appendix 5.
The HAA subcontracts to an organization to serve as its gatekeeper. The current HAA gatekeeper program grantee is the Housing Counseling Services, Inc. The gatekeeper program is the centralized source for housing services, housing related financial assistance, and information for individuals and families living with HIV/AIDS in the District of Columbia.

The gatekeeper program services comprise:

1. Short-term assistance towards housing-related expenses, such as rent, mortgage payments and utility bills. PLWHA who lose their jobs or are forced to stop working because of a major illness or hospitalization or had sudden decrease in income are eligible for short-term assistance.
2. A continuum of housing options to individuals and families with HIV/AIDS. The independent living and supportive housing programs offer stable housing from three months to two years. Participants in these programs are covered by the Tenant Based Rental Assistance (TBRA) program. The emergency housing program provides referrals for emergency housing for HIV positive individuals, including families with children, for up to 30 days.
3. Training/counseling and advocacy services.
4. Housing Information and Referrals Services (HIRS) program. As part of this program, a comprehensive list of affordable housing is published every week and made available to the clients. Other HIRS activities include outreach, referrals to case managers and participate in community events to promote gatekeeper services.

The gatekeeper is required to submit a monthly report to the HAA. The monthly report includes the following information:

- Summary of gatekeeper program services.
- Summary of client intakes for the month and the status of each application; demographics of client intakes.
- Summary of short term assistance applications approved during the month.
- Report on the meeting with HAA service providers.
- Current list of approved TBRA clients who are waiting to be referred to a housing provider.
- Current list of clients approved for supportive housing who are waiting to be referred to a housing provider

The Gatekeeper receives monthly client roster report from the housing providers. These reports provide information on TBRA assistance – date of entry into the program, voucher number, address of the housing unit, size of the unit in terms of number of bedrooms, family size, contract rent, client contribution and vendor rent payment to the landlord, and dates of inspection and certification of the unit.
Summary of services provided by the gatekeeper during the period 10/1/2004 to 5/31/2005 using HOPWA funds

Housing services information

Housing Information and referral services: 1121
Requests for Short-Term Assistance: 133
Short-Term Assistance approved: 99
Housing applications received: 152
Housing applications approved: 65
Psychological assessments completed: 133
Clients referred to housing providers:
  TBRA: 27
  Supportive housing: 6
  Shelter + Care: 10
New TBRA vouchers issued: 17
Vouchers reissued: 21
Supportive housing waiting list: 54
(33 male, 20 female, one (1) transgender, eight (8) adults with children, and 46 single adults, 35 with no fixed address and 19 living in shelter, earliest wait date: 2/5/03)
TBRA waiting list: 103
(earliest approval date 1/23/04)

Demographic information of service recipients

Number of PLWHA who received only support services: 288
Number of persons who received only housing services: 833

Numbers served by gender:
  Male: 223
  Female: 79
  Transgender: 14

Numbers served by age:
  17 years & under: 2
  18 to 30 years: 35
  31 to 50 years: 228
  51 and older: 51

Numbers served by race:
  Black: 250
  Hispanic: 42
  White: 15
  Other: 10
Gross monthly income of service recipients at the time of program entry

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 to $250</td>
<td>164</td>
</tr>
<tr>
<td>$251 to $500</td>
<td>18</td>
</tr>
<tr>
<td>$501 to $1,000</td>
<td>84</td>
</tr>
<tr>
<td>$1,001 to $1,500</td>
<td>38</td>
</tr>
<tr>
<td>$1,501 to $2,000</td>
<td>7</td>
</tr>
<tr>
<td>$2,001+</td>
<td>6</td>
</tr>
</tbody>
</table>

The Housing Opportunities for Persons with AIDS (HOPWA) program was created in 1992 to address the housing needs of PLWHA. The program, run by the U.S. Department of Housing and Urban Development (HUD), has been successful in addressing the housing and service needs of people living with HIV/AIDS. The program is currently assisting over 77,200 households, that include 28,100 with rental assistance (50% of the costs); 43,900 with short-term payments (24% of the costs); 5,200 in housing facilities (20% of the costs) and 400 new units being developed (5% of the costs).

The costs by type for the HOPWA formula programs during 2002-2003 are:

- Housing subsidies and operating costs: 57%
- Housing information and permanent placement: 5%
- Related supportive services (case management): 35%
- Administrative costs: 3%

Part of the program success has been in its ability to leverage funds and support from mainstream housing programs. HUD reports that 52,800 leveraged units of HIV housing efforts have been reported by formula grantees. Leveraged funding amounts to $269 million and for every HOPWA dollar $1.88 of other housing funds are leveraged. However, development projects are reported to leverage $4.01 per HOPWA dollar.

Despite the success of HOPWA there is still a great unmet need. With a large number of PLWHA in need of housing assistance, HOPWA can hardly meet the growing need. In the past 13 years the program has grown from 38 formula jurisdictions to 122 in 2005. In fact, for FY2006, 2 new jurisdictions are expected to become eligible for HOPWA funding, yet proposed funding have dropped dramatically. From FY2004 to FY2005 the program was cut by 13 million; for most existing jurisdictions, this will result in a net loss of funding, and subsequently, a loss of housing.

Funding HOPWA programs sufficiently to meet the growing need is vital not only to people living with HIV/AIDS, but also to the broader continuum of housing and services providers. Through the flexibility of the program HOPWA has become a vital component of the Continuum of Care process in communities across the country. The HOPWA program and mainstream housing programs, such as Section 8, have come to create a network of housing opportunities that work to better serve all those in need of housing.

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62 HUD Office of HIV/AIDS housing: Web cast for Formula Grantees on changes in CAPER. Available at www.hud.gov/offices/cpd/aidshousing
63 Ibid.
assistance and services. It is critical that all of these interdependent programs receive full and appropriate funding levels in order to successfully serve all those in need.
CHAPTER VI

AN INTEGRATED MONITORING AND EVALUATION PLAN

Monitoring and Evaluation of Community-based Programs

The previous section discussed homelessness and housing issues as it applies to PLWHA. We saw that even as many housing programs are being funded by different government agencies and implemented across the country, homelessness still remains a serious problem for persons living with HIV/AIDS. No doubt the different programs, including the HOPWA program, has had a measure of success in meeting the housing needs of this section of the population. But HOPWA funds are insufficient to meet the growing demand for housing that the evolving nature of the disease has brought about. In a climate where housing funds for PLWHA fall short of their needs, the effective utilization of available funds is of primary importance. Effective utilization of funds calls for a continuous monitoring and evaluation of programs. In this chapter we discuss monitoring and evaluation of community-based programs with particular emphasis on HOPWA funded housing programs for persons living with HIV/AIDS.

Program monitoring and evaluation is becoming an increasingly important activity for funding agencies to assess actual accomplishments against objectives and thus judge whether program assistance has been successful or not. This is particularly true of community-based programs. In order to insure that scarce public and private resources are being utilized optimally and to assure the public that the management of funded programs by government departments has the desired effects on communities, it is necessary to have sound monitoring and evaluation plans. Monitoring and evaluation mechanisms are also required to ensure policy and practices are based on the best available evidence. Systematic monitoring and evaluation will ensure that individual programs are part of a larger positive process and contribute to the overall objectives and priorities of the state and even the nation. It will also provide an accountability mechanism for use by all concerned parties.

Monitoring and evaluation of health programs is receiving greater attention than ever before. There is a considerable amount of literature that argues that focused monitoring and evaluation of health-related programs contribute to improved health outcomes by measuring the program’s performance in relation to its stated purpose and priorities at all levels of implementation, and with particular reference to the program’s efficiency in terms of health outputs and outcomes.

Functions of monitoring and evaluation

**Information function:** A program monitoring and evaluation system supplies information on matters such as efficiency, legitimacy, effectiveness, impact, relevance and sustainability of the program interventions. Such information may be used:
• as indications of strength and weakness of the program and/or activities, showing which activities require special attention;
• to strengthen the program management;
• to account for the use of inputs;
• to further develop strategies and policies; and
• to influence public opinion.

**Education function:** A monitoring and evaluation system provides regular feedback, thereby giving fresh insights into program process which in turn provides learning experiences to practitioners and funders.

**Coordination function:** Through a systematic and regular exchange of information among program stakeholders, monitoring and evaluation helps individuals and groups build partnerships and strengthen networks.

**Program Monitoring**

*Monitoring is collecting information that will help organizations answer questions about their programs and projects.* For monitoring to be effective, such information should be collected in a planned and organized way. Most organizations routinely collect and maintain files, records, registers and notes. But this information collection becomes monitoring only when it is collected and maintained in accordance with some predetermined plan. Information collected as part of a monitoring plan seeks to answer questions such as: how well are we doing? Are we doing the right things? What difference are we making? In other words, monitoring has the objective of creating data which are to be compared to explicit standards. These standards are mostly in the nature of desired future conditions or program outcomes. In the case of multi-site programs, such standards may relate either to a specific site where the program is being implemented or to an entire geographical area. Monitoring provides information through time about whether the program is moving towards its objectives. This information can then be used to effect an action of some kind – either maintaining the program in its current course or making necessary changes to steer its course toward the desired objectives.

There are three types of monitoring. The first is *Implementation Monitoring.* This monitoring involves determining the level of activity and the compliance of activities with previously determined plan. This monitoring is best done annually to determine if the planned programs and activities were put into effect and completed. The second is *Effectiveness Monitoring* which assesses how well the goals and expectations are being met. The third is *Validation Monitoring,* which assesses whether key assumptions made in estimating the outcomes are valid. Which of these monitoring types is used will depend on the monitoring objectives.
Steps in designing a monitoring plan

The first step in successful monitoring begins with clearly stating the purposes for which the activity is being undertaken. Broad monitoring objectives must follow from the management objectives. Monitoring objectives must be realistic and attainable and should focus on solving the problem or issue and be developed in such a way that it helps decision making. Monitoring objectives should preferably be developed involving as many stakeholders as possible.

In order that monitoring objectives are set realistically having due regard to time, expertise and money available, the following questions should be asked before setting objectives:

1. Does this objective help management make an informed decision?
2. How can this objective be statistically evaluated?
3. What is the cost of the objective? Do costs correspond to benefits?
4. What is the timeframe in which this objective can be achieved?

In the case of HOPWA housing program, monitoring objectives might be developed from asking the following questions:

1. What are the trends in the growth of Continuum of Care housing facilities in the District, what are the present and future needs, and what is the gap?
2. What are the trends in HIV/AIDS incidence among various subpopulations and particularly those most at-risk? How should their needs be assessed and prioritized?
3. What housing services are needed most, who should provide it, and how should they be prioritized?
4. Are HIV/AIDS services distributed within the District wards on the basis of their varying needs?
5. Are the organizational objectives of sub-grantees in line with those of the HAA? Do they have the required organizational structure and staff capabilities to address the tasks assigned to them effectively?
6. Have the sub-grantees clearly defined strategic and annual plans that correspond to the HAA objectives, goals and action plans?
7. Are funds being managed efficiently, used effectively and for the purpose for which they are meant?
8. Have they met the periodic (monthly, quarterly, semiannual, annual) targets set? If there are shortcomings, how do they plan to rectify the situation?
9. Are PLWHA experiencing positive changes that are associated with the policies and activities? Are these the policies and activities the PLWHA, their families and broader communities want? Are they accepting of these?
Some examples of monitoring objectives could be:

1. To track the housing gap for PLWHA;
2. To survey and track incidence of HIV/AIDS among some sub-populations such as seniors, teens, women and those reentering the society after a period of incarceration.
3. To keep track of the special needs for housing and support services among PLWHA in different wards.
4. To ensure that all grantees and sub-grantees are working toward a common and well-defined goals and objectives.
5. To ensure that funds are being utilized for agreed purposes and in an efficient manner.
6. To ensure that targets are being met.
7. To ensure that the program outcomes are in the right direction.

Once the monitoring objectives have been set, the next step is to identify the indicators that will be monitored. Such indicators may well be qualitative while some are quantitative. The indicators must be good determinants of the characteristics of concern. It may be necessary to pare down the indicators to a manageable level. Ideally, indicators should be:

- Valid – they should measure the conditions or events they are intended to measure;
- Reliable – produce the same results when used more than once to measure the same condition or event;
- Specific – they should measure only the condition or event they are intended to measure;
- Sensitive – they should reflect changes in the state of the condition or event under observation;
- Operational – it should be possible to measure or quantify them;
- Affordable – the costs of measuring the indicators should be reasonable; and,
- Feasible – it should be possible to carry out the proposed data collection.

Some examples of indicators that may be monitored are:

1. The number of PLWHA who are homeless.
2. The number of PLWHA living in different types of housing.
3. The supply and demand for different types of housing;
4. The change in number of AIDS cases among special populations.
5. The need for different types of services (childcare facilities, transportation, food packages, adherence specialist, case managers) and their availability.
6. Utilization of funds – both in terms of its efficiency and effectiveness.

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7. The achievement of predetermined targets in terms of, for example, number of referrals, number of clients placed in permanent housing, number of vouchers issued and their utilization.
8. A fall in numbers hospitalized or length of stay in hospitals.

The next monitoring step is data collection and management. Relevant and quality data must be collected and maintained over time. Only by maintaining consistency in the collection, analysis, and management of long-term datasets can trends be measured accurately. Sound data management systems are key to successful quality assurance and a credible monitoring program. A sound data management will encompass all of these activities: data entry, data verification, data validation, data documentation and data archival.

The next step in monitoring is data analysis. A proper analysis of monitoring data should result in the following:65

- Analyses should ensure that questions on program implementation that are being monitored are effectively answered;
- Analyses should ensure the early detection of problems and deviations from set plans, thereby allowing for timely and lower cost solutions to such problems;
- Results of analyses should contribute to the knowledge of the system being monitored and how it impacts client populations; and,
- Results of analyses should provide program managers with a scientific rationale for setting quality standards.

According to the HUD’s office of Community Planning and Development, monitoring efforts of organizations implementing programs funded by HUD should include:66

- Identifying and tracking program and project results;
- Identifying technical assistance needs of their organizations as well as those of their sub-grantees;
- Ensuring timely expenditure of funds;
- Documenting compliance with program rules;
- Preventing fraud and abuse; and
- Identifying innovative tools and techniques that support program goals.

HUD further states that in order for effective monitoring, a system should be developed and incorporated into the service delivery system at the program design stage. The monitoring system should identify the reports to be prepared by its program staff as well as other external staff connected to the program through sub-contracts. Examination of these reports help program implementers assess performance and identify any compliance issues.

HUD also reiterates that apart from collection and examination of reports, monitoring should include in-depth performance assessment of selected sub-contractors through on-site visits. On-site monitoring involves a visit to the program to gather specific information and observe actual program implementation processes. But on-site visits are both time and resource consuming, not all organizations should be covered under this monitoring technique; it is essential to carefully determine which organizations and program areas should receive special attention through on-site visits. Selection of organizations should be based on identification of risk factors such as failure to comply with program requirements, fraud, or abuse of funds. For this purpose, it is necessary that monitoring staff develop a list of risk factors.

According to HUD, some of these risk factors include:

- Inability to clear outstanding issues;
- Inaccurate/incomplete/late submission of progress reports;
- Failure to meet agreed-upon schedules;
- Poor program documentation;
- Lack of progress in spending funds;
- Staff turnover/inexperienced staff;
- Significant changes in goals and direction of administering agency;
- Lack of or poor quality organizational strategic plan;
- Use of a large number of sub-contractors.

HUD recommends the prioritizing these risk factors on the basis of weights assigned to each risk factor and acting upon the more urgent ones (the risks could be evaluated as severe, moderate and low).

**Monitoring Plan for Housing Providers**

HOPWA sub-grantees, housing provider organizations, need to monitor their progress as well and need to have an annual monitoring plan. Such a plan should include the following elements:

- Organizational aims: Identify the target group to which the organization provides services and enumerate the changes it wants to bring about in the target group.
- Organizational objectives: Objectives relate to the specific aims. These are practical activities that are carried out to bring about the desired changes in the target group.
- Performance indicators: Once objectives have been set out, project outputs and outcomes relating to each of the objectives need to be described. Outputs describe the program’s activities, services and products. Outcomes describe the desired or planned changes or benefits in the target group as a result of the activities.
- Information collection methods relating to each output and outcome.
- Evaluation methodology
- Reporting the results in the format set by the funders.
Program Evaluation

*Evaluation is about using monitoring and other information collected to make judgments about the project against preset specific criteria.* Both monitoring and evaluation help organizations assess how well they are doing in order to help them do it better. They help them answer two vital questions in program implementation – (1) what has happened and why? And, (2) what is and what is not working?

Although monitoring and evaluation work hand-in-hand, it is necessary to distinguish between them:

- Monitoring activity is undertaken to answer the question of whether a program has achieved its objectives. Evaluation is undertaken to answer the more fundamental questions of why a program has worked or not worked and what changes should be undertaken to improve its working.
- Monitoring involves setting program goals and outcomes, identifying indicators to measure the progress of the program toward its objective, and the collection of data regarding the indicators and reporting periodically on the progress. Evaluation involves collection of quantitative and qualitative data to assess the program performance.
- The objective of program monitoring is to continually examine the progress of the program during its entire life, and to compare this progress against outcomes that have been previously set. Monitoring serves as an early warning system to the program managers and administrators and as a tool for improving accountability to the public. Evaluation allows for an overall assessment of the program as it is being implemented so that adjustments that may improve its results could be identified and made. Program evaluation is also used to determine whether a program “caused” outcomes to be achieved.

Table 36 indicates through a matrix, the distinctions between the monitoring and evaluation processes.

**Table 36**

<table>
<thead>
<tr>
<th></th>
<th>Monitoring</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>To assess progress towards project objectives</td>
<td>To determine relevance, effectiveness, efficiency, impact and sustainability; To learn lessons</td>
</tr>
<tr>
<td><strong>Main users</strong></td>
<td>Internal to the project</td>
<td>External to the project</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td>Continuous during project implementation</td>
<td>Occasional, during and/or after the project</td>
</tr>
</tbody>
</table>
Monitoring provides the raw data about the program. But in and of themselves these data are useless and costly. Evaluation puts these data to use and gives them a purpose. Evaluation leads to learning as questions are answered, recommendations are made and improvements are suggested. However, while much importance is given to program evaluation, very little importance is attached to monitoring. Without regular monitoring, evaluation will have no data. Monitoring is needed to support a comprehensive, scientifically-based evaluation of the present and future condition of the target communities the program seeks to serve, and its ability to sustain itself over extended periods of time. In this sense monitoring and evaluation are interconnected. Monitoring programs should be carefully designed on the basis of full knowledge of how the data and information will be used for evaluation purposes. Monitoring is a means of checking on progress as well as a tool for improvement. Without monitoring, there is no way of knowing if the management actions are working and how they should be changed to be more effective; nor without monitoring can any meaningful evaluation be carried out.

Program evaluations help grantees, service providers, and policy makers assess the effectiveness of their programs in reaching target populations, the extent to which the objectives were met, and the impact and efficiency of their programs. Evaluation empowers program staff and participants to develop specific criteria for assessing program effectiveness and to use the findings for program improvement.

**Evaluation of HIV services**

A report of the Human Resources and Service Administration of the Department of Health and Human Services recommends that when evaluating the accessibility, quality and outcomes of HIV services, the following factors need to be taken into account:

- Characteristics of health/social service professionals - knowledge and attitudes, HIV-specific training and experience, and cultural competence.
- Organizational characteristics – eligibility requirements, convenience of location and hours of operation, average appointment waiting time, availability of on-site ancillary services, and adoption and enforcement of clinical care guidelines.
- Characteristics of the HIV service delivery system – number of organizations providing services, number of different services provided, extent to which service organizations maintain regular contact with each other, and adoption of system-wide standards of care.
- Health policy environment – level of federal and state funding for HIV related services, interstate variations in Medicaid and other benefits, immigration and welfare issues, and federal and state guidelines for HIV/AIDS health care.

The major tasks involved in program evaluation, and the order in which they should preferably be undertaken, is listed below.

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• Develop an evaluation plan and project a timeline for the tasks to be completed;
• Conduct literature review;
• Develop a study design that includes a description of the evaluation questions and the variables to be studied;
• A data collection plan, a sampling plan (if applicable), a data analysis plan, and procedures for protecting the confidentiality of client records and study participant identities;
• Prepare regular progress reports of the evaluation process in order to make midcourse corrections, if necessary;
• Collect evaluation data through surveys, interviews, focus groups, and/or secondary sources;
• Analyze evaluation data.
• Prepare a written report that describes the purpose, methodology, and findings of the evaluation and make recommendations for program improvement;
• Make an oral presentation on the evaluation to all stakeholders.

The AIDS Housing of Washington, a Seattle-based organization has prepared a booklet “Tools for Outcome-Based Evaluation of HOPWA Grantees.” This guide is intended to assist HOPWA grantees in implementing outcome-based program evaluation. The program outcomes and indicators for each of these outcomes are presented in the section ‘Program Outcomes and Indicators Digest’ The guide also contains illustrative samples of logic models and evaluation plans. A copy of the guide may be seen at Appendix 6.

Evaluation Plan

Incorporating an evaluation plan into the program even at its design stage is essential to ensure that evaluation will have served the desired purpose. Planning an intervention and designing an evaluation strategy should be inseparable activities. A typical evaluation plan should describe the overall purpose(s) of the evaluation, the specific evaluation questions to be addressed, the evaluation designs and methods to be used, what data are to be collected and how, the resources (financial and human) that will be needed, and the evaluation timeline.

The rationale for developing an evaluation plan includes:

• Evaluation planning will provide program managers and stakeholders alike with the opportunity to assess the evaluation needs, resources, capabilities and priorities in their respective areas;
• Having an evaluation plan will show stakeholders how the program plans to be accountable for the resources they have received;
• In the process of developing an evaluation plan, existing data sources and past or concurrent evaluation policies and activities are often identified. Analyzing

existing data sources and past evaluative efforts can lead to a more efficient, less redundant plan for future evaluations;

- Having a long-term evaluation plan can clarify future decision making regarding evaluation processes and priorities; and,
- Having a comprehensive evaluation plan in place favorably influences decision making.

**Steps involved in the design of an evaluation plan**

Evaluation planning involves several steps that are similar to the steps involved in the design of monitoring plans. Stakeholders should all be involved in drawing up the plan. The first two steps in the evaluation process, namely identifying the program goals and objectives and data collection, would have been carried out at the monitoring stage. The third step would be to identify internal and external evaluation resources. Such resources may include, apart from funds, personnel, databases, and computer systems.

The fourth step involves setting evaluation questions, appropriate evaluation designs, data needs, and the methods by which this information will be collected and analyzed. An operational plan for the comprehensive evaluation plan should be developed at this stage. At the end of this plan, there will be available a written plan briefly outlining the evaluation questions and evaluation design, data collection methods and analysis plan, and overall timeline for the execution of the plan.

The next step is to plan for using and disseminating the evaluation findings. This step is rarely performed, but should be because it is extremely useful in ensuring that evaluation findings are used to inform program improvement and decision making. The question, “how has the evaluation plan been implemented and how have the results been used to improve programs and policy?” can never be answered adequately in the absence of this step. It is quite likely the evaluators have completed their task and either forgotten the details (internal evaluators) or moved on (external evaluators). Inadequate dissemination also leads to redundancy in evaluation efforts because others are not aware of the findings and have no information on the basis of which they can make decisions to improve the future evaluation efforts or the programs themselves.

After an evaluation plan has been developed, it is time to assess the technical capacity of the staff to carry out the evaluation activities. Some traditional methodologies in evaluation, such as surveys and interviews, may not always be appropriate for all evaluations. Technical guidance is especially important in complex evaluation designs, such as quantitative surveys where sampling designs, sample sizes, and questionnaire design and statistical analyses are used. Particularly with HIV programs, combining quantitative and qualitative measurement tools is important.

**Challenges**

In the final analysis, the goal of an effective monitoring and evaluation system for the HAA housing services unit should be to improve the overall quality and efficiency of
service delivery to PLWHA. In this sense, a good and efficient monitoring and evaluation system for the HAA would be one that results in the collection and analysis of data that capture improvements in the use of limited resources, on the one hand, and the maximization of health outcomes for PLWHA, on the other. Specific objectives of a monitoring and evaluation system for the HAA housing unit could be summarized as:

1. To provide feedback for policy, priority setting, and resource allocation.
2. To inform policy makers and program implementers the problems and perceptions of all stakeholders, including PLWHA.
3. To provide evidence of a wider housing service system impact through HOPWA program.

Some inherent monitoring and evaluation challenges that are relevant to the housing services program of HAA include:

- Monitoring activities at the HAA may be expected to be largely coordinative – coordinating the data received from the sub-grantees. The effectiveness of HAA monitoring unit will, therefore, be influenced by the quality and timeliness of data inputs received from the sub-grantees. Since programs are determined centrally but implemented in a large number of sites with differing needs and priorities, coordination of monitoring and evaluation activities becomes a challenging task.

- Baseline data are critical for good monitoring systems and for reliable evaluations. Baseline studies provide a measurable benchmark against which subsequent performances can be measured. The value of baseline studies becomes more apparent over time as they allow us to measure change from a previous period. Successive studies of the program progress help us to compare its quality and effectiveness with earlier ones. This information assists project planners and executors in developing achievable goals, tracking the progress, effect mid-course corrections wherever and whenever necessary, and aid program evaluation. (The use of baseline data to determine the required annual percentage change to meet the target is illustrated with an example in Appendix 7). However, there are challenges to collecting baseline data in the case of housing and other services to PLWHA because of the large number of institutions and programs involved. It is difficult to isolate the changes brought about through implementation of any single program. Additionally, many of the variables are qualitative making such measurements difficult.

- Since HIV/AIDS service provision involves many stakeholders and partners, and since the PLWHA come from wide-ranging demographic groups with differing cultures and practices, monitoring and evaluation design must take into account not only program specific factors but several other related factors as well.
Having regard to the three objectives, and the above mentioned monitoring and evaluation challenges, some recommendations for action are made in the following paragraphs.

**Recommendations**

**1: Ensure timely collection of data**

The monitoring and evaluation system should provide timely feedback for programs and systems reforms within the department. Since data comes from a large number of sub-grantees, the HAA housing services monitoring and evaluation system should consider the speed of data generation, retrieval and analysis both of itself and that of the sub-grantees.

**2: Set up a performance-based system**

Monitoring and evaluation should inform a performance-based system both within the department and in the sub-grantees. There has to be an across the board understanding and acceptance of the fact that monitoring and evaluation systems are in place not so much to fulfill reporting requirements but to track and guide performance. This requires the integration of monitoring and evaluation into policy making and resource allocation decisions and processes.

**3: Set the right questions that should guide the design of an effective monitoring and evaluation system**

*The suggested monitoring and evaluation questions for HAA*

- Are housing and other services being received by PLWHA and are they being provided in a timely fashion?
- Is the target population being reached?
- Is housing stock along the continuum of care increasing? Is this increase being achieved cost effectively?
- Are services being provided by qualified providers?
- Are the costs of service delivery reasonable?
- Are there adequate safeguards against fraudulent claims and over utilization?
- Are we responding quickly enough, through feedback systems, to policy and operational needs as the program and client needs are evolving over time?
- Are we paying sufficient attention to the training needs of our staff as well as the organizational capacities of service providers?

*The suggested M&E questions for local service providers*

- Are we meeting our goal of operational efficiency – through good organizational and management practices? Are we paying attention to organizational capacity building?
• Are we keeping our clients satisfied in the services they receive – are their needs being met in the most effective manner possible?
• Do our policies and actions promote sustainability?
• Is the target population being reached?
• Are we expanding our service base?
• Are we helping our clients in a timely manner and in a culturally appropriate manner?
• Are the staff satisfied with the processes that are in place in the department? Are they trained regularly to meet changing client and program needs?
• Are we building partnerships and are our existing partners satisfied with the collaborative efforts?

4: Promote Participatory Monitoring and Evaluation Process

Monitoring and evaluation is increasingly adopting participatory methods. Participatory monitoring and evaluation (PME) involves the assessment of change through processes that involve all groups that are affecting or are affected by the impacts being assessed. Involving those affected by the impacts results in improved public accountability and improved information for strategic planning at different levels. This process involves a shift from an external expert-dominated evaluation approach towards one with major community involvement.

The United Nations Development Program (UNDP) defines participatory evaluation as:

Participatory evaluations involve the collective examination and assessment of a program or project by stakeholders and beneficiaries. Participatory evaluation is people-centered whereby project stakeholders and beneficiaries are the key actors of the evaluation process and not the mere objects of the evaluation. Participatory evaluations are reflective, action-oriented and seek to build capacity by:
(1) providing stakeholders and beneficiaries with the opportunity to reflect on a project's progress and obstacles; (2) generating knowledge that informs practice and leads to corrective actions; (3) providing beneficiaries and stakeholders with the tools to transform their environment.

Benefits of PME are that it:

• creates ownership over evaluation results by project participants and implementing groups
• increases consensus on project goals, objectives and activities
• provides timely, reliable, and valid information for management decision making
• enhances learning by local stakeholders

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enhances skills and confidence of local groups in program management
utilizes local knowledge
increases cost-effectiveness of monitoring and evaluation information.

In order for PME to work, the participants must:

• Accept evaluation as an internal need and responsibility, and not as a threat;
• Appreciate the need for partnerships among all stakeholders for program implementation;
• Be open to using qualitative indicators;
• Understand participation as a valuable democratic process;
• Include a process of carefully defining who ‘the community’ is, to avoid missing key people;
• Establish community awareness through training in the PME process;
• Include a local community coordinator or other liaison/intermediary institution;
• Allow enough time to develop the PME process; and,
• Ensure prompt analysis and feedback/use of PME findings.

Implementation of a successful PME process is challenging as each stakeholder group may have different information needs, priorities and expectations of being involved in monitoring and evaluation. A system which reconciles these differences should be designed for this process to succeed. A collaborative team made up of project and partner organizations and community should all have a shared responsibility for PME. To initiate a successful participatory evaluation process, a written participatory evaluation plan needs to be developed through a series of planning meetings so that all participants are aware of and agree on what will take place. Ideally, these meetings take place during project design and start-up phases. The plan describes how the activities in the PME activities will be carried out. It should include the following items:

• description of the project’s approach to PME and the process used to develop the worksheet;
• description of the key users of monitoring and evaluation information and their specific information needs;
• list of monitoring and evaluation team members and their responsibilities;
• Monitoring and evaluation training plan;
• annual implementation schedule;
• schedule of project reports, assessments and evaluations;
• project logical framework;
• budget for monitoring and evaluation activities.

5: Develop Rolling Baselines

Monitoring and evaluation, by definition, compare changes over time, or ‘before and after’ situations. In order that quantitative evaluation of social or community programs or the impact assessment of such programs have validity, there is need for the use of statistical analyses that use techniques such as the randomized control model and pre-post treatment model – with or without control groups or counterfactual outcomes for measuring program impact. Such statistical models are not inherently applicable to evaluate the HOPWA program since it is difficult to find a control group that has not received housing and/or other eligible services.

The effective method to assess program impact is to compare baseline data to later data. However, lack of baseline information is a serious problem in most community-based programs. One approach to overcome this challenge is to construct retrospective baseline information, but this too has weaknesses due to selective and distorted recall.

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The rolling baseline technique represents a middle-ground between a comprehensive baseline survey and a retrospective impact assessment. The rolling baseline moves away from a single event-oriented *success/failure* philosophy that characterizes year-end evaluations. It uses data from relevant preceding periods and as the baseline for the next period. The assumption is that there should be a trend in improved program effectiveness over time as new system technologies, policies, procedures, and structures are introduced. Since different interventions will focus on different concepts, showing a trend over time provides a means to assess which concepts have the greatest potential (in this sense, rolling baselines are a continuing process as they establish new and revised goals for each new cycle of goals and targets). Developing stable scenarios will facilitate study responsiveness and the ability to compare the effects of new capabilities to those in the baseline.
CHAPTER VII

SURVEY OF HOUSING PROVIDERS

Strategies to improve housing and other services for PLWHA require a comprehensive understanding of both the specific populations and subgroups in greatest need for such services and of the nature and extent of existing services and the population they target. Information on existing services can reveal gaps in services relative to need, and thereby inform policy decisions and improve coordination of resources. Such information can be important for helping to identify unmet service needs, for suggesting new services, and for improving the monitoring of existing services.

The Howard University Center for Urban Progress designed a questionnaire for the purpose of collecting information on various issues that impact the functioning of HIV/AIDS service providers receiving HOPWA funds (see Appendix 8). The survey was designed to be a mail survey, with e-mail follow-up contact as necessary. The main objective of the questionnaire was to gather information from service providers so that their views and experiences are reflected in the strategic plan. The key issues addressed in the questionnaire are summarized in Table 37.

Table 37
Key Issues addressed in the survey questionnaire

<table>
<thead>
<tr>
<th>Issues</th>
<th>Summary of questionnaire items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource characteristics</td>
<td>The questionnaire includes items about services provided and the number and types of service recipients.</td>
</tr>
<tr>
<td>Populations served</td>
<td>The questionnaire asks about the populations served.</td>
</tr>
<tr>
<td>Service delivery area</td>
<td>The questionnaire collects information about the geographical locations served by the providers.</td>
</tr>
<tr>
<td>Budget</td>
<td>The questionnaire includes items on amount, source and expenditure budgeted by the provider organizations.</td>
</tr>
<tr>
<td>Data and evaluation</td>
<td>Questions about report and evaluation requirements are included in the questionnaire.</td>
</tr>
</tbody>
</table>

Questionnaires were sent to twenty organizations and replies were received from eleven. The replies received have been analyzed and the findings are presented in this chapter. The organizations that responded to the questionnaire include:

United Planning Organization
301 Rhode Island Avenue, NW
Washington, DC 20001

Building Futures
1440 Meridian Place, NW
Washington, DC 20010
The geography and demographics of PLWHA serviced by housing providers

Wards serviced by HOPWA funded HIV/AIDS housing providers

Table 38 presents information on the wards/neighborhoods served by the responding organizations. Of the 10 responding organizations, seven provide services to all eight wards while three provide services to selected wards.
Table 38

Wards serviced by HOPWA funded HIV/AIDS housing providers

<table>
<thead>
<tr>
<th>No. of Wards Served</th>
<th>No. of Service Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>

The length of the period the providers have been providing HIV/AIDS care-related services

The responding organizations have been providing services for four years or less. Table 39 shows the number of years the housing providers have been providing HIV/AIDS related services, including housing, to PLWHA in the District.

Table 39

The length of the period the providers have been providing HIV/AIDS care-related services

<table>
<thead>
<tr>
<th>Years in service</th>
<th>No. of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4 and above</td>
<td>4</td>
</tr>
</tbody>
</table>

Specific populations being served

While many (6 of the 11 service providers who responded to the question) serve all PLWHA, there are some that provide services to targeted groups/subpopulations. Details of number of organizations serving general HIV/AIDS populations and special subpopulations are presented in Table 40.
Table 40

Populations Served by Service Providers

<table>
<thead>
<tr>
<th>Population/subpopulation</th>
<th>No. of organizations providing services</th>
</tr>
</thead>
<tbody>
<tr>
<td>All populations</td>
<td>6</td>
</tr>
<tr>
<td>Transgender, gay, bisexuals, and Lesbians</td>
<td>2</td>
</tr>
<tr>
<td>Male, female, transgendered</td>
<td>1</td>
</tr>
<tr>
<td>Women only</td>
<td>2</td>
</tr>
</tbody>
</table>

Number of clients served by race/ethnicity and gender

Table 41 presents details of the number of clients served by the responding organizations, the race/ethnicity and gender of the clients during the past twelve months.

Table 41

Number of Clients Served by Race/ethnicity and Gender

<table>
<thead>
<tr>
<th>Client categories</th>
<th>Numbers served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of clients</td>
<td>58,871</td>
</tr>
<tr>
<td>Adults (age 21 and above)</td>
<td>43,689</td>
</tr>
<tr>
<td>Adolescents/youth (age 13-20)</td>
<td>11,001</td>
</tr>
<tr>
<td>Children (age 12 and under)</td>
<td>4,181</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>52,281</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4,607</td>
</tr>
<tr>
<td>White</td>
<td>844</td>
</tr>
<tr>
<td>Others</td>
<td>1,139</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>22,375</td>
</tr>
<tr>
<td>Female</td>
<td>36,128</td>
</tr>
<tr>
<td>Transgendered</td>
<td>368</td>
</tr>
</tbody>
</table>

Types of services offered by housing providers

The HIV/AIDS housing providers offer a number of services besides housing. Table 37 provides details of services provided and the number of organizations providing those services. Table 42 presents similar information of case management services.
Table 42

Types of services provided and the number of organizations providing those services

<table>
<thead>
<tr>
<th>Types of Services</th>
<th>Number of Organizations offering the services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling substance abuse</td>
<td>6</td>
</tr>
<tr>
<td>Mental health services</td>
<td>4</td>
</tr>
<tr>
<td>Health education</td>
<td>5</td>
</tr>
<tr>
<td>Adult education</td>
<td>2</td>
</tr>
<tr>
<td>Nutritional support</td>
<td>3</td>
</tr>
<tr>
<td>Day care</td>
<td>1</td>
</tr>
<tr>
<td>Childcare</td>
<td>2</td>
</tr>
<tr>
<td>Legal services</td>
<td>1</td>
</tr>
<tr>
<td>Employment assistance services</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol and drug abuse/rehabilitation</td>
<td>2</td>
</tr>
<tr>
<td>AIDS Drug Assistance Program</td>
<td>2</td>
</tr>
<tr>
<td>Permanent housing placement</td>
<td>5</td>
</tr>
<tr>
<td>Supportive housing</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 43

Types of case management services provided and the number of organizations providing those services

<table>
<thead>
<tr>
<th>Case management services</th>
<th>Number of Organizations offering services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal assessment of clients</td>
<td>8</td>
</tr>
<tr>
<td>Development of individualized plan for care management</td>
<td>7</td>
</tr>
<tr>
<td>Identification of appropriate sources of care</td>
<td>8</td>
</tr>
<tr>
<td>Referrals</td>
<td>9</td>
</tr>
<tr>
<td>Monitoring and follow up</td>
<td>9</td>
</tr>
</tbody>
</table>

Housing Services

Of the 11 housing providers who responded, only three (3) provide some kind of financial assistance for housing costs (including rent, mortgage, utilities, rental deposits, and move-in assistance for PLWHA) while six (6) provide facility based housing. Of these six housing, there are two (2) each of permanent/supportive housing, temporary/transitional housing, emergency housing. Among the two permanent housing,
one has 20 units and the other has 5 beds in supportive housing; one temporary/transitional housing facility has six (6) units and the other one has flexible arrangements making units available based on needs; and of the two emergency housing, one has 5 bedrooms in a large building and the other has four units. Four of the six facility based housing own the property while rest have leased the property.

Sources of finance and expenditure

The housing providers raise funds from a variety of sources to carry out their operations. Apart from HOPWA funds, housing providers raise funds from the U.S. Department of Housing and Urban Development (HOME and Section 811 funds), state/local governments, communities, rental payments and subsidies, and other private funding sources. Almost all organizations used the funds to provide services to PLWHA. But they distributed their expenditure between housing and other support services in different proportions. Table 44 presents information on the distribution of expenditures of the housing providers between housing and other support services.

Table 44

<table>
<thead>
<tr>
<th>Organization</th>
<th>Expenditure on housing (%)</th>
<th>Expenditure on other support services (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>71</td>
<td>29</td>
</tr>
<tr>
<td>2</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>30</td>
<td>70</td>
</tr>
<tr>
<td>6</td>
<td>35</td>
<td>65</td>
</tr>
</tbody>
</table>

General issues

Training and evaluation

All, except one of the responding organizations reported that their staff participated regularly in capacity development training programs. The same number of organizations also indicated that their performance was being evaluated on a regular basis. However, the evaluation methodologies followed by these organizations varied considerably. The evaluation methodologies adopted by these organizations include:

- Ongoing evaluation process through monthly meetings
- Evaluation through external evaluator who produces a formal annual evaluation report
- Evaluation twice a year by both internal and external evaluators
• Annual evaluation by funding agencies including Department of Mental Health, Community Partnership, and U.S. department of Housing and Urban Development.
• Evaluation by internal evaluators.
• Quarterly site visits by HIV/AIDS Administration (HAA), which also reviews files and budgets and ensures compliance with other grant conditions and requirements.

Addressing health disparities

The questionnaire included a question on how the service providers were addressing the issues related to disparities in health outcomes based on race/ethnicity, gender, and geographic location within the District. The respondent organizations indicated that they mainly address racial, gender, and geographic disparities in health outcomes for PLWHA through community collaborations and building partnerships with other service providers. One organization wrote:

_We are working to collaborate with other agencies to provide services to populations which are not currently funded to provide service. We provide referrals and do monitoring outcomes to follow up on clients we refer out for services. One population would be women especially since there is an increase in HIV/AIDS amongst this population. We are participating in trainings to help us better understand how to address racial, gender, and geographical disparities in health outcomes within our community for people living with HIV/AIDS._

Yet another replied:

_(We are) collaborating with social service agencies, social workers, and other CBOs (community based organizations) to provide a comprehensive standard of care that is culturally sensitive to include all clients regardless of gender, race or sexual orientation._

The replies received from all responding organizations to the question on how they handle disparities in health outcomes for PLWHA in their respective communities are summarized below:

• Provide case management services and ensuring that each client has accessible medical services. Case management is also used to specifically ensure that families are following through treatment plans.
• Training staff in cultural competency to interact with different subpopulations.
• Provide referrals and monitor outcomes as a follow up on clients referred to other services.
• Build partnerships and develop collaborative arrangements with other service providers to ensure that all subpopulations are served.
• Educate the public about local and community issues facing PLWHA and promote advocacy.
• Provide counseling services as well as training clients in accessing appropriate services and proper housing.
• Documenting their studies, developing case studies and best practices manual that can be used by a wider cross section of service organizations in the city.

**Barriers to better performance and capacity building**

The responding organizations were asked to list three barriers that their respective agencies faced in providing services to PLWHA. One organization identified the barriers as:

*Program compliance for dealing with drug addiction; getting potential applicants that are eligible for rental assistance; and, providing services to chronically mentally ill consumers.*

Yet another organization found the following three as barriers to providing effective services:

*Late payment by HIV/AIDS Administration; bureaucracy at other agencies providing housing assistance; and, availability of limited services for people who use substances.*

The replies received from the organizations are summarized below:

• Difficulties associated with program administration - lack of funds for administrative costs and bureaucratic delays in providing housing assistance by the agencies concerned, including the HIV/AIDS Administration;
• Lack of training facilities for skills building among service providers and case managers;
• Lack of resources for follow-up activities including adherence to medication;
• Not in my backyard (NIMBY) attitude in some communities and lack of sensitivity to the needs of some specific subpopulations;
• Special problems involved in providing services to the mentally ill and those who abuse substances; and,
• Lack of sustained and consistent income among clients

The questionnaire included a question on the areas for training and capacity building that service providers considered most helpful to increase the effectiveness of their service activities. Their recommendations included:

• Training in working with people from different cultures\(^{72}\) (cultural competency)
• Greater opportunities for providers to meet and exchange information including best practices (networking and partnership building)

\(^{72}\) Central American cultural training was specifically mentioned
• Training in health care with a view to gaining additional knowledge/experience in antiretroviral treatments, opportunistic infections, monitoring and verbalizing patients' health care needs
• Training in handling drug abuse and alcohol addicted patients
• Training in fund raising

Strengths of the housing programs as they exist today

The respondents were asked what they considered the major strengths of their programs. One organization identified its strengths as:

Providing stable housing for those that need assistance; being able to direct program participants with multiple needs; and, providing a support system that many (clients) need.

Another organization identified its strengths as:

Being culturally competent; (exhibiting) sensitivity towards people from other cultures; and, having an expedient process for housing.

Focusing on housing services, yet another organization identified its strengths as:

Developing and maintaining effective housing plans with specific goals/tasks that ensure clients housing and their ability to maintain their housing. In addition, our strength lies in our ability to provide support services.

Yet another organization identified its strength as being gender specific and that:

(we) are able to address the needs of the people we serve because we understand the issues they face.

The organizational strengths of the respondent organizations are summarized below:

• Supportive housing environment with case management services available to all residents;
• Cultural competency and sensitivity to the needs of different subpopulations;
• Expeditious intake process for housing;
• Good staff who work hard to get services to people in the face of many hardships including bureaucratic impediments;
• Provision of stable housing combined with an effective support system;
• The development and maintenance of effective housing plans with specific goals/tasks;
• The ability to address the needs of specific subpopulations as a result of a good understanding of the issues that they frequently confront.
Recommendations

The organizations were asked to recommend measures to strengthen the housing program. Their recommendations are listed below:

1. There is a need for greater sensitivity and understanding of the needs of transgender individuals, despite considerable progress in this regard. Many members of this subpopulation continue to be homeless either due to lack of specific policies in this regard or slow implementation of existing policies. Homelessness affects their stability.

2. Encourage greater community participation in HIV/AIDS related workshops to help them understand the issues involved in HIV/AIDS healthcare better.

3. Provide training to residents on being good care givers, while also taking care of themselves and their homes.

4. Provide more opportunities for training in cultural competency, particularly as it relates to transgender individuals.

5. Develop a means by which transgender individuals assimilate in different communities through creating housing opportunities and employment opportunities in these communities, thereby increasing the diversity in the District.

6. There has to be greater efficiency in the administration of housing programs through cutting red tapes and reducing bureaucratic impediments that cut into the time that could be better spent with the clients.

7. There needs to be an increase in the number of housing providers in the District.

8. The clients should be allowed longer periods of stay in shelters and transitional facilities.

9. There is a need for more experienced people in various support services that PLWHA need.

10. There needs to be more funds allotted towards capital improvements.
CHAPTER VIII

HOUSING STRATEGIC PLAN: 2006 - 2010

Introduction

A strategic plan of an organization focuses on its future and outlines its plans and actions that shape and guide its activities. Organizations function most effectively and efficiently when their work is guided by a long-term strategic plan. Strategic plans are essential to ensure that members of the organization are working toward the same goals, and enable the group to assess and adjust the organization’s direction in response to changing environments. Once a strategic plan is carefully conceived and designed with relevance to the organizational mission and goals, the plan becomes the basis for work plans. This is particularly important in case of organizations that serve some of the most vulnerable sections of the populations under conditions of scarcity of financial and other resources in the health sector.

The Rationale for a Strategic Plan

The situation for PLWHA in the District is continuously evolving. There are more people living with HIV/AIDS in the District than ever before. While many continue to benefit from advances in AIDS treatment, many others still face health, economic, social, and personal disadvantages related to their HIV/AIDS status. The complexity of issues facing PLWHA continues to grow as the epidemic affects an increasing number of people from marginalized backgrounds. PLWHA increasingly battle issues of poverty, homelessness, mental health, and other conditions that challenge their well being. At the same time, the health, social service and economic supports available to them are being eroded by reduction in government funding.

In order to meet the long-term needs of this section of the population it is necessary to have a clear strategic plan. A clearly researched and analyzed strategic plan is expected to provide the HIV/AIDS Administration (HAA) with the following benefits:

- Establish District-wide direction in key policy or functional areas to move away from crisis-driven decision-making to a clearly stated and universally known process;
- Facilitate the management of all resources – human and financial - in a manner that addresses the critical issues facing the District now and in the future;
- Make all stakeholders more responsive to the needs of PLWHA by placing greater emphasis on results and outcomes than on simply service efforts;
- Bring critical issues to the focused attention of policymakers for review and debate;
- Provide a context to focus on the activities and processes of the HAA and to improve its accountability for the use of resources;
- Establish a means of highlighting the policy concerns of the public and public officials with the HIV/AIDS program implementation efforts of HAA and to
build interagency, intergovernmental, and public/private/nonprofit partnerships; and

- Provide a forum for communication between service providers and the constituents they serve.

The District of Columbia Department of Health HIV/AIDS Administration
HOPWA Program – An Organizational Overview

The District of Columbia Department of Health HIV/AIDS Administration (HAA) is the HOPWA Formula Regional Grantee for the Washington D.C. Eligible Metropolitan Statistical Area (EMSA) that includes, apart from the District of Columbia, Suburban Maryland, Suburban Virginia, and Suburban West Virginia. The EMSA contains racially and ethnically diverse population as well as inner cities and rural areas. The HOPWA funds are distributed among these jurisdictions in the following ration: D.C – 56.6 percent; Maryland – 24.8 percent; Virginia – 17.6 percent and West Virginia – 1 percent. The mission of the HAA is “to prevent the spread of HIV transmission and to ensure the management, oversight, planning, and coordination of HIV/AIDS services and programs in the District of Columbia, in collaboration with other government and community organizations.”

The HIV/AIDS Housing Coordinator in the Health and Support Services Division of HAA provides programmatic oversight for all HOPWA providers in D.C. This division ensures that all District agencies responsible for providing housing to persons with special needs, including the Commission on Mental Health, Addiction Prevention and Recovery Administration, D.C. Housing Authority, The Community Partnership for the Prevention of Homelessness (a D.C. based non-profit that works with D.C. Administration on preventing homelessness in the District), and the HIV/AIDS Administration, come together and share information with a view to increasing the effectiveness and efficiency of HIV/AIDS service delivery system in the District. Currently the HAA has also established a grant agreement with the D.C. Housing Authority to provide Housing Quality Standards inspections for all HOPWA funded housing units. This collaborative effort is expected to ensure that clients have quality housing.

The HAA Housing Program provides housing support services and discharge planning activities. To acquire additional Shelter Plus Care (S+C) funding, the Housing Division participates in the Homeless Continuum of Care application process administered by the Community Partnership for the Prevention of Homelessness. The HAA-funded housing infrastructure is supported by $1.2 million S+C dollars and $1.455 million in D.C. appropriated dollars. However, the HAA does not have direct access to CDBG, HOME, and ESG grants.

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The housing program unit of the HAA, the focus of this report, provides housing assistance to PLWHA and those affected by HIV/AIDS. It serves the housing needs of men and women living with HIV/AIDS, in a manner that enhances their independence and dignity. Its operations reflect its recognition of:

- The diverse and changing needs of PLWHA;
- The diverse communities affected by HIV/AIDS; and
- The importance of providing relevant and responsive services in partnership with other service providers.

The HAA utilizes the services of a gatekeeper, Housing Counseling Services Inc. in the District to help PLWHA access housing services. The gatekeeper provides housing information and referrals, maintains the centralized waiting list, provides comprehensive assessments, and ensures that the client and his/her social worker establish a housing work plan. The gatekeeper also links the client with the most appropriate type of housing assistance such as emergency assistance, short-term rent, mortgage and utility assistance, tenant-based rental assistance and supportive housing for those who are not prepared for independent living. The gatekeeper also works closely with the housing providers who are subcontracted by the HAA to provide housing and other support services to PLWHA.

**Strategic Plan for Ending Homelessness for PLWHA**

The D.C. Administration has recently presented a strategic plan for ending homelessness in Washington, D.C. by 2014 74 (See Appendix 9). The vision of this strategic plan is “to improve the quality of life for all residents of the District of Columbia by preventing and ending homelessness within ten years.” The three policy directives for achieving the goals are:

- Increase homeless prevention efforts using local and federal resources;
- Develop and/or subsidize at least 6,000 new units of affordable, supportive permanent housing by 2004; and
- Provide wraparound mainstream supportive services fully coordinated with Continuum of Care programs and special needs housing.

The strategic plan for PLWHA outlined in this chapter is based on the broader plan for the city and draws its specific goals and activities from the Homeless No More plan.

**The HOPWA Housing Program Strategic Plan**

*Vision: Provide services to people living with HIV/AIDS in the District of Columbia through an efficient and effective system that promotes the health, self-sufficiency, and responsibility of individuals and families.*

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**Mission:** The mission of the housing program of the HAA is the provision of a continuum of care housing facilities to PLWHA with specific commitment to:

- **Promote the health, well being, stability and quality of life for all PLWHA;**
- **Consistent with its role as the most proximate and relevant government agency in the District in regard to housing for PLWHA, housing program of HAA remains committed to promoting equity in the provision of housing services through addressing the unique housing needs of all subgroups of the population – men, women, youth, seniors, persons exiting the criminal justice system, gays, lesbian and transgenders.
- **Develop and deliver services that are caring, client-centered, culturally appropriate, responsive, timely, and relevant to the needs of the clients.**

**Goals and Activities**

**Goal A**

Reduce chronic homelessness among HIV/AIDS population in the District of Columbia by 30 percent by 2010.

**Objectives:**

1. Increased health care facilities including mental health and substance abuse treatments to the chronically homeless.
2. Increased independence and quality of life for the chronically homeless PLWHA.
3. Improved chances of adherence to medication regimen.
4. Reduced frequency in hospitalization and duration of stay.

**Strategies:**

**Strategy A1: Conduct an assessment of existing housing and future housing needs for PLWHA having regard to the changing context of the epidemic and the people affected by the disease.**

Needs assessment is the cornerstone of any program planning process. It refers to the “process of gathering and analyzing information from a variety of sources in order to determine the current status and unmet needs of a defined population or a geographic area.”

The resulting information on service needs, available resources, and access barriers can be used to identify service gaps and develop strategies for filling these gaps. This information is invaluable in developing, improving, and/or expanding the HIV/AIDS continuum of care. In conducting a needs assessment, the HAA will promote active and informed participation of the community, including PLWHA, and service providers.

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The housing needs assessment study should incorporate the following:

- An epidemiologic profile that describes the current status of the epidemic in D.C., with special emphasis on the prevalence of HIV/AIDS in the hard-to-reach subpopulations. This section will describe past, present and future trends in the epidemic.
- An assessment of service needs among the affected populations and the barriers to accessing existing services. Information should be collected from a sample of PLWHA who use the services and those who are unconnected and hence do not use the services. Service providers should also be encouraged to provide information on service needs and barriers.
- An inventory of current resources that provides a comprehensive picture of the continuum of services for PLHA in the District. This inventory should be comprehensive, and without regard to funding sources.
- A summary of provider capacity and capability in the District that examines the extent to which services identified in the inventory are actually available, accessible and appropriate for PLWHA. Capacity assessment should include a description of which services and how much of each of these services a provider can provide. Assessment of capability will describe the extent to which each provider’s services are physically and geographically accessible, culturally appropriate, and available at convenient times.
- Finally, an assessment of gaps in services that is derived from all of the quantitative and qualitative data collected on service needs, resources, and barriers. This information should be used to set future priorities and allocate resources most appropriately.

The needs assessment study should be conducted by a suitable consultant who should be carefully selected based on pre-determined selection criteria. A Needs Assessment Committee comprising major stakeholders should be set up by HAA to monitor the progress of the study.

**Strategy A2: Improve the rate of utilization of Tenant-based Rental Assistance Vouchers.**

Through the Tenant-based Rental Assistance Voucher Program (TBRA), the administering housing authority issues a voucher to an income-qualified household, which then finds a unit to rent. If the unit meets the Section 8 quality standards, the PHA then pays the landlord the amount equal to the difference between 30 percent of the tenant's adjusted income (or 10 percent of the gross income or the portion of welfare assistance designated for housing) and the PHA-determined payment standard for the area. The rent must be reasonable compared with similar unassisted units. A study on Section 8 voucher success rates conducted by Abt Associates Inc.\(^7\) estimates that

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nationally, 69 percent of families and individuals in large metropolitan areas who received vouchers succeeded in using them to lease units under Section 8 program.

In metropolitan areas which are witnessing rapid gentrification and the consequent rising costs of housing, landlords who own rental property in desirable neighborhoods may not see strong incentives to participate in the TBRA program. In many metropolitan areas today, including Washington, D.C., rental housing demand is very strong; vacancy rates are low, prevailing rent levels are rising, and landlords do not have any difficulty finding market-rate tenants for units in good neighborhoods. Under these circumstances, landlords obviously do not take into account TBRA vouchers to lease units they own in desirable neighborhoods. In fact, some landlords avoid participating in this program altogether because they do not want to become entangled in red tape and bureaucratic complications, and when market demand is strong, these landlords have no reason to change their minds. Moreover, Section 8 programs need efficient administration; programs that are not efficiently administered have particular difficulty attracting landlords with properties in desirable neighborhoods. Only landlords who cannot otherwise find paying tenants for their properties are inclined to overlook these difficulties and inefficiencies. Thus TBRA tenants become renters of last resort, after every other alternative has been tried and eliminated. Additionally, large families – those needing units with three or more bedrooms – often have difficulty using vouchers. This is due both to shortage of supply and reluctance to rent houses to families with children.

According to an Abt Associates report on the LIHTC submitted to HUD, in metropolitan areas with “high housing costs relative to incomes also often are places where it has been relatively difficult at times for low-income families to use housing vouchers.” Where there is a constrained supply of rental housing, it is easy for owners to rent voucher-qualifying units only to unsubsidized households. An unusually low success rate in the use of voucher may indicate housing market difficulties. In the District of Columbia the rate of utilization is slated to be less than 60 percent. Low rates may also reflect poor administrative practices on the part of authorities.

TBRA recipients may face additional barriers gaining access to housing in predominantly white neighborhoods, even if units are available below Fair Market Rents. To some extent, locational outcomes may reflect either the preferences or the fears of minority participants. Nevertheless, we know that housing market discrimination persists at very high levels in rental housing markets. Although increasing numbers of minority households in the District have gained access to suburban neighborhoods such as Prince George’s County in the past two decades, researchers continue to find evidence that minorities face significant barriers to entry into white suburban neighborhoods. Even after controlling for socioeconomic status, minorities are significantly less likely than


whites to move to predominantly white neighborhoods and more likely to move to minority or racially mixed neighborhoods79.

The Abt Associates study found that of all practices and procedures that could improve the success rate – briefing for voucher holders, policies for extending the permitted search time, policies for screening households, housing search assistance, and outreach to landlords – the only practice that was statistically significant was landlord outreach. So it imperative that service providers reach out to landlords and build strong advocacy groups to improve TBRA utilization success rate and reduce the waiting period.

Meeting the housing needs of lowest-income groups among the PLWHA poses a dual challenge. Because it is so difficult to build affordable units, the strategy for the HAA should be to preserve and improve where necessary the existing supply of lowest cost housing. Secondly, it needs to be recognized that, in the absence of regular employment and income gains among the PLWHA, and because developers simply cannot and will not build and operate units at rents they can afford, subsidies are the only way to provide decent housing for the lowest-income households. So the strategy for HAA should be to provide subsidies for housing. Thirdly, lack of community cooperation hinders the ability to replace low-cost units that are lost from the housing stock. Only a few communities to date are accepting of higher-density developments on affordable housing set-asides. Public attitudes will need to change from resistance to acceptance of a mix of housing types, process and rents. This calls for a strategy for active outreach and advocacy to educate the public about the need for community agreements and acceptance of mixed income housing.

**Strategy A3: Work with state’s housing policy makers on a state-wide strategy for creating/increasing set aside housing units for PLWHA**

The housing needs of all PLWHA in the District of Columbia cannot be met with HOPWA resources alone; other low-income and affordable housing programs are necessary additional resources. Perhaps one of the biggest obstacles to developing homeless, low-income, or affordable housing funding is the lack of flexibility that the many housing funding streams allow in the design of projects. Many providers seeking to develop transitional housing projects, or other non-traditional forms of supportive housing, may find it difficult to adapt their programs to fit within the guidelines of these funding streams. These providers struggle to strike a balance between obtaining available sources of funding simply to make a project happen and ensuring the integrity of a particular program design/concept. A feasible strategy for HAA would be to work with state’s housing policy makers on a state-wide strategy for the use of LIHTC and HOME funds for set aside units for PLWHA.

Low Income Housing Tax Credit (LIHTC) has, since the late 1980s, been the primary vehicle for building or rehabilitating housing with rents affordable to low-income

individuals and families. Effective and optimal use of LIHTC for building or rehabilitating housing for PLWHA will help create affordable housing for this population. The recommendations made in the Abt Associates study on the use of LIHTC\textsuperscript{80} and making more affordable units available are worth reviewing in this context:

- Developing new units of affordable housing is only one way, a fairly limited way, of alleviating shortages of rental housing. There is substantial evidence that high or increasing rents and house prices are associated with regulations that add to development cost. Reducing regulatory barriers that contribute to high housing costs in metropolitan areas could be a more effective way of promoting affordable housing.
- Provide additional set-asides
- Preserve affordable housing that already exists in neighborhoods where housing prices are increasing rapidly due to gentrification. Preserving these developments as affordable housing will enable low-income families to live in mixed income neighborhoods with transportation facilities.
- Preference for acquisition and rehabilitation of properties ‘at risk’ of becoming unaffordable.

Another factor that needs to be considered is the availability of larger housing units, with three or more bedrooms, for women with children and families with HIV/AIDS. A report of the Abt Associates inc.\textsuperscript{81} shows that whereas 5,763 units were placed in service between 1995 and 2002 using LIHTC funds, the average number of bedrooms in these units was only 1.8. Many families are unable to utilize TBRA vouchers due to the shortage of larger units.

The factors that have to receive greater attention in developing affordable housing units for PLWHA using LIHTC funds are (1) reducing regulatory barriers; (2) providing set-asides for low-income PLWHA; (3) Acquiring and/or rehabilitating properties that are either abandoned or are at risk of becoming abandoned; and (4) making available affordable units for families that may need large apartments.

HOME is part of a system for rental housing subsidies. Local housing officials could use this fund to supplement the voucher program, increase the stock of rental housing affordable for voucher holders, and/or use HOME funds to expand the neighborhoods where low-income renters can live. Which of these options, individually or in some combination, is chosen by state housing officials will depend on the larger housing strategy for the jurisdiction. A policy paper\textsuperscript{82} prepared by Abt Associates, Inc. for HUD makes recommendations for the best use of HOME funds. The recommendations that are most relevant to creating housing opportunities for PLWHA in the District are listed below.

\textsuperscript{80} Ibid.
• Where there is a shortage of rental housing, HOME and LIHTC funds should be considered to produce additional units of affordable rental housing;
• New HOME rental developments should be located in neighborhoods where vouchers are difficult to use;
• Focus HOME rental developments for large families, who often have difficulties finding affordable rental housing that meet their needs; on the elderly; and people with disabilities who prefer to live in ‘mainstream’ housing, but sometimes need the supervision possible in a specialized housing development or can benefit from living in a community of people with similar needs.

The recommendations made in the two reports on the best use of LIHTC and HOME funds clearly point to the potential for using the funds in a targeted manner for PLWHA. There needs to be a clear recognition among policy makers that housing is a priority for PLWHA and policies and strategies need to be put in place to make housing available to PLWHA on a priority basis. Simply bracketing them with those low-income groups who are in need of housing will only aggravate the issue in the long run.

<table>
<thead>
<tr>
<th>GOAL A</th>
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<tbody>
<tr>
<td>Reduce chronic homelessness among HIV/AIDS population in the District of Columbia by 30 percent by 2010.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activities</th>
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</thead>
</table>
| A1: Conduct an assessment of existing housing and future housing needs for PLWHA having regard to the changing context of the epidemic and the people affected by the disease. | 1. Select an intermediary organization to conduct the needs assessment study.  
2. Appoint a Needs Assessment Committee of major stakeholders to monitor the study.  
3. Allocate resources to implement the plan to address unmet housing needs. |
| A2: Improve the rate of utilization of tenant-based rental assistance vouchers. | 1. Reduce bureaucratic delays and improve administrative practices in the administration of TBRA program in the District.  
2. Identify larger housing units (with 3 or more bedrooms) for families of PLWHA and help them to successfully negotiate with landlords.  
3. Identify housing units in mixed income neighborhoods for PLWHA and their families and build advocacy groups to educate the public about the need the change the ‘not in my backyard (NIMBY)’ attitude.  
4. Actively pursue landlord outreach to improve TBRA utilization rates.  
5. Preserve and improve the existing supply of low-cost housing. |
Goal B

Increase the effectiveness and efficiency of HIV/AIDS housing and other services organizations.

Objectives:

1. Promote organizational and managerial capacity of HIV/AIDS service organizations, thereby promoting the sustainability of community AIDS efforts.
2. Consolidate HIV/AIDS services into a ‘one-stop-shop’.

Strategies:

Strategy B1: Promote better coordination among agencies that provide services to PLWHA.

PLWHA require a full range of services that include health care, mental health, and substance abuse remediation, besides housing. In most communities, HIV/AIDS service delivery systems comprise a diverse group of organizations that include hospital-based clinics, local health departments, and community-based organizations. The mix of services provided by individual organizations varies, with some offering a wide range of services and others offering only a single specialized service. In this environment, PLWHA must often seek care at several organizations to obtain the services needed by them.

In many communities, there is the likelihood of a certain disconnect or lack of coordination among these service organizations as each system works within its sphere of activity with disregard to what is happening in other delivery systems. Given that AIDS patients are quite often multiply diagnosed and co-morbidities are common, the need to coordinate all these services is of considerable importance. It is common for PLWHA to
receive case management services from more than one system, with each unaware of the other’s existence, when a comprehensive continuum of care services would be more effective and efficient. The best method to create such comprehensive service is to develop a system of care administration that ensures that all service organizations work collaboratively to provide the full range of services PLWHA need.

According to a study conducted in Baltimore, “clients and providers are frequently frustrated by fragmentation and duplication of services that have arisen as a consequence of the emergence of many HIV/AIDS related programs in the community”. Whatever inter-organizational cooperation and collaborations exist, they are on an ad hoc basis without any formal agreement of such collaboration. Structural coordination involving ongoing interagency activities is the exception rather than the rule. It is important that interagency collaborations be formalized by encouraging agencies to enter into formal arrangements to refer clients to each other. The aim of forming referral linkages is to connect PLWHA to services they need. Such linkages help both the service providers and their clients.

For PLWHA, effective linkages between point-of-entry agencies and HOPWA service providers can help them:

- Receive critical health and social services;
- Improve health status;
- Enhance quality of life; and
- Lengthen life.

For HOPWA service providers, effective linkages can:

- Clarify responsibility among HOPWA service providers and other service agencies;
- Foster successful, system-wide service coordination;
- Ensure that referral process endures through staff turn-over;
- Generate new relationships with linked organizations;
- Help the monitoring system for both providers and their partners; and
- Facilitate continuity of care among multiple providers for individual clients.

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Information about the overall structure of HIV/AIDS service delivery network in the District is an important tool in making decisions about the feasibility and impact of major system-changing efforts such as creating a single point of entry for clients or consolidating many services into a ‘one-stop-shop’. The HAA should ensure this information is available to it at all times.

In the light of the foregoing discussion, one of the most important strategies for improving HIV/AIDS housing is to promote interagency coordination and promote linkages between them. Such coordination will ensure that limited housing resources are utilized in the most beneficial manner. This will no doubt call for unprecedented levels of cooperation among government agencies and community-based organizations. Yet no efforts should be spared to encourage such cooperation. Furthermore, as the Baltimore study mentioned earlier found, housing agencies have to play a central role in the HIV/AIDS service delivery system. Housing agencies occupy an important place in the service delivery system both as recipients of clients and as initiators of client referrals. Their staff often interacts with their clients on a relatively frequent basis and thus have the opportunity to recognize needs as soon as they arise and work proactively with other organizations to help clients meet their needs.

**Strategy B2: Enhance the organizational and managerial capacity of service providers.**

There is a growing recognition among health care organizations that, while technical and financial inputs are critical for improving project performance, this assistance alone is not sufficient to help them manage and monitor their growth, define their vision and design effective strategies to adapt to a dynamic environment. As mentioned earlier in this report, the HIV/AIDS epidemic is evolving over time. Hence, HIV/AIDS services need to be scaled-up on a regular and on-going basis for an effective response to the epidemic. Capacity building has become central to health sector assistance strategies.

Capacity building is a process that builds core competencies essential to increasing the effectiveness and sustainability of HIV prevention within an organization or community. ‘Organizational capacity’ refers to the ability of organizations to translate their missions into achievable goals and accomplish them. Capacity building comprises three major activities: skills building, technical assistance, and technology transfer.

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Strategy B3: Set performance standards for service providers and ensure that housing services meet or exceed quality standards through quality assurance and management.

“Quality standards are explicit statements of expected quality in the performance of a healthcare activity.”\(^{88}\) They may take the form of procedures, guidelines, standard operating procedures, or statements of expected healthcare outcomes. Standards define expectations for how a particular healthcare activity will be performed in order to produce the desired results.

“Quality management activities seek to enhance the quality of HIV care provided and increase access to quality services. They do so by measuring how health and social services meet established professional standards and user expectations.”\(^{89}\) The CARE Act legislation directs grantees to implement quality management programs. According to HRSA, Quality Management Programs should have the following characteristics\(^{90}\):

1. Be a systematic process with identified leadership, accountability, and dedicated resources available to the program;
2. Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks;
3. Focus on linkages, efficiencies, provider and client expectations in addressing outcome improvement;
4. Be a continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities; and
5. Ensure that data collected is fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

Strategy B4: Implement a system-wide monitoring and evaluation program.

Monitoring and evaluation of health programs is receiving greater attention than ever before as powerful tools in the management of effective health care systems. Monitoring and evaluation activities allow program managers to assess the extent to which programs are being implemented and are achieving the intended objectives. Monitoring aggregates information across sites and time and optimally serves as a tool to highlight for program managers which program components may need to be strengthened or modified to reach specific goals. On the other hand, evaluation assesses the worth or value of a program over time through a more detailed analysis of their outcomes and their impact on the target population. Evaluation can potentially


link observed outcomes and impacts and the program process. Tracking trends over time through routine monitoring and evaluation efforts will help program managers and decision-makers in assessing how successful programs are in meeting goals.

### GOAL B
**Increase the effectiveness and efficiency of HIV/AIDS housing and other services organizations.**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activities</th>
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</table>
| B1: Promote better coordination among agencies that provide services to PLWHA. | 1. Collect data on the overall structure of HIV/AIDS service delivery network in the District and use it for policy making decisions.  
2. Promote inter-organizational linkages by encouraging them (and assisting them) to enter into formal arrangements to refer clients to each other instead of the present ad hoc arrangements.  
3. Create a more structural and administrative mode of coordination among service organizations through the creation of a ‘clearing house’ type of organization.  
3. Make housing agencies the central core of the HIV/AIDS service delivery system since they are likely to be most connected to all organizations. |
| B2: Enhance the organizational and managerial capacity of HAA staff and service providers. | 1. Describe the capacity characteristics for HAA staff and HIV/AIDS housing and other service providers.  
2. Identify the gaps in the capacities of HAA staff and service providers.  
3. Develop a program to deliver sustained and coordinated capacity building training/assistance to HIV/AIDS service providers.  
4. Develop infrastructural mechanisms needed to provide capacity building assistance through carefully selected intermediaries. |
| B3: Ensure that housing services meet or exceed quality standards through quality management. | 1. Define the evidence-based performance standards that result in better health outcomes for PLWHA.  
2. Disseminate the performance standards to service providers. |
3. Identify gaps in and barriers to quality of care and services.
4. Identify appropriate strategies to address these gaps and barriers.
5. Implement the strategies to facilitate service providers perform according to standards.
6. Set up a quality assurance mechanism within the HAA, if necessary. Otherwise utilize the existing mechanism to ensure adherence to quality standards.

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<thead>
<tr>
<th>Strategy B4: Implement a system-wide monitoring and evaluation program.</th>
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<tbody>
<tr>
<td>1. Develop a monitoring and evaluation plan.</td>
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<td>2. Identify monitoring and evaluation indicators.</td>
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<td>3. Develop instruments for data collection and analysis.</td>
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<td>4. Report evaluation results to key stakeholders.</td>
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**Goal C: Ensure equitable access to HIV/AIDS housing and other services.**

**Objective 1:** Bring the marginalized HIV/AIDS subpopulations into mainstream services.

**Strategy C1: Provide targeted service to women, youth, seniors, Hispanics, PLWHA in custodial settings and those released from prisons, transgenders, and the ‘unconnected’.**

In some communities certain groups of PLWHA may suffer some form of discrimination resulting in the denial of fair and equal opportunity to access to health care. In order to meet the specific needs of these groups, targeted interventions that address the specific barriers they often face are necessary. These groups include the poor (financial barriers to treatment), young people (lack of information, barriers to providing legally valid informed consent), women and girls (discrimination, disproportionate burden of care giving activities, threat of violence), prisoners (prison conditions and policies), people released from prisons (social isolation), and people with disabilities (physical isolation).

Besides the ethical argument of providing equal access to these groups, there is also a public health argument that underlines the critical importance of ensuring service access by these vulnerable populations. Reaching them with effective services is vital for slowing down the spread of HIV. Failure to do this means further increasing their vulnerability to HIV and fuelling the spread of the epidemic.

The rationale for targeting each of these subpopulations and is discussed in the ensuing paragraphs.
Women

Over the past 20 years there have been significant epidemiological shifts in patterns of HIV transmission, which have led to new understandings of risk and vulnerability. Whereas in the early stages of the epidemic, HIV infection was predominantly among men, since 1993, AIDS cases among this women have been growing rapidly, and in some cities such as the District of Columbia, at a rate faster than among men.

As mentioned earlier, in the District of Columbia for the period 1998-2002, females accounted for 29 percent of the AIDS cases. Equally disturbing is the fact that while the number of diagnosed AIDS cases among males continues to decline, it is increasing in the case of females. Heterosexual contact is now the greatest risk factor for women. They now account for over 25% of all AIDS cases. Ninety percent women reported with AIDS are black; in 2003 the rate of AIDS diagnosis for black women was 25 times the rate for white women and 4 times the rate for Hispanic women.91 Compounding this problem is, according to a recent Centers for Disease Control and Prevention (CDC) study, the fact that HIV infected women are less likely than similarly infected men to receive prescriptions for the most effective treatments for HIV infections.92 This group needs special attention in terms of housing too as often they are single mothers living below poverty level and quite often children are involved. There are also selected barriers to adherence to antiretroviral medications in this subgroup due to the associated stigma, depression and lack of social support, and domestic violence.

Women with HIV/AIDS in D.C. continue to face numerous barriers to care; housing has emerged as one of the most significant crises facing women with HIV/AIDS.93 Women with HIV/AIDS need special attention when it comes to housing. Often children and whole families are homeless. A vast majority of women with HIV/AIDS in D.C. lives in poverty (90 percent reporting annual income below $12,000)94 and with skyrocketing housing costs, housing becomes unaffordable to most women. Women and their families need expanded health care and family support. In addition, since women are in most cases care givers, the needs of home care givers should be assessed and met. Additional needs for women are adequate child care services and coordinated mother-child health services.

Youth

Another subgroup that needs special attention is the youth (age less than 22). Over the past decade, the number AIDS cases reported each year among U.S. adolescents has

93 Ibid.
increased substantially. According to the CDC, at least 40,000 new cases of HIV infection occur each year in the United States and as many as 50% of these may be among young people under the age of 25, and as many as 25% may be among young people under age 22. 95 Among adolescents reported with AIDS, older teens and racial and ethnic minority teens are disproportionately affected. Although African Americans and Hispanics represent approximately 25% of the U.S. population, they account for 56% of adolescent males with AIDS and 82% of adolescent females with AIDS. The proportion of females among U.S. adolescents with AIDS has more than tripled in the last 10 years - from 14% in 1987 to 46% of the reported cases in 1996. Young women particularly face substantial risk of becoming infected with HIV due to biological factors in addition to social factors. According to a 1998 CDC study, HIV prevalence among young women (2.8 per 1,000) was higher than among young men (2.0 per 1,000) and African American women were 7 times likely as white women and 8 times as likely as Hispanic women to be HIV positive. 96

Management of HIV/AIDS among young people requires a variety of assistance and referral networks for their range of problems. Helping young people avoid HIV/AIDS also requires helping them improve their social conditions that place them at risk, such as education, employment training, and job placement assistance. Reaching young people effectively requires programs both to be located places that are easy to access and to be available at convenient times. Special attention must be paid to young people who are particularly hard to reach, such as those who are outside the school system, without housing, or in unsafe home environments. Engaging young people and representative groups in decision making about program design is an important way of gaining an improved understanding of their needs and helps towards the creation of more responsive programs. Efforts to engage citizens in decision-making and priority-setting should include young people, making them full partners in establishing equitable access to treatment and care for persons living with HIV.

**People in custodial settings and people re-entering society from prison systems**

A report of the Urban Institute found that 54 percent of the homeless people in the U.S. had been incarcerated 97 and an estimated 20-26 percent of all HIV/AIDS cases in the U.S. were those released from prisons. Similar data is not available for the District. However, according to the latest data available (2002), total of 563 AIDS cases were incarcerated at the time of diagnosis. The proportion of incarcerated individuals diagnosed with AIDS is growing in recent times. Women account for about 12 percent of the cases. People with injection drug use history account for 67 percent of AIDS cases.

In the correctional environment there are often barriers to prevention and standards of care. This group is a target for priority action in this strategic plan due to the risk of transmission by inmates on their return to the community. The high levels of needle sharing and the rate of transfer of inmates between and within custodial settings increases the risk of a rise in HIV among people in correctional facilities. As these inmates return to the community they have very little economic, social and community support and are likely to be homeless. There is also a likelihood of risky behavior among this subpopulation that may result in higher rates of infectivity. Attending to the physical and mental health needs of this subpopulation and housing them appropriately should be central to any effort to reducing homelessness among PLWHA.

In this context, it is worthwhile reviewing some findings of a study of the homeless who had previously been incarcerated conducted in Baltimore. Although this study includes all the homeless and not specifically those with HIV/AIDS, the findings give a great deal of insight into the magnitude of the problem that those recently released from the prison system face once they reenter the community. Nevertheless, it should be noted that these findings are relevant to those who are infected with HIV/AIDS and reentering the community after incarceration to even a greater degree because of the additional complications caused by the infection. Some of the major findings of this study (based on the survey of 720 homeless in Baltimore City) are:

- 63.3 percent of the ex-prison population in the sample owned or rented housing before their incarceration. Only 29.9 percent had permanent housing after they were released from the prison.
- 67 percent of respondents who had been incarcerated reported having a physical illness, and 39.5 reported having mental illness. However, only 21.6 percent reported receiving medical health care while in prison and 8.3 percent reported receiving mental health care.
- 67 percent of the people stated that, upon release, they were not directed by the Department of Corrections to any services. This included referrals to housing service providers, health care or substance abuse treatments.
- 58 percent reported housing was their most critical need.
- One in three felt that their incarceration adversely affected their chances of receiving public housing, 30.6 percent felt it would decrease their ability to obtain private housing, and 30 percent felt they faced a bias or stigma in private housing market because of their previous incarceration.
- 42.6 percent of the respondents felt that their incarceration impacted their employment.
- Top barriers to finding permanent housing were reported to be (i) paying the security deposit (52.8%); (ii) not having a stable employment (47.9%); and, (iii) paying utilities (44.2%).

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Housing HIV/AIDS infected individuals leaving the criminal justice system on a priority basis is a socially, economically and fiscally effective policy strategy for the administration. The effort offers simultaneous opportunities to reduce the rates of homelessness (since this subpopulation constitutes one of the highest rates of the homeless) on the one hand, and reduce recidivism (since recidivism is comparatively higher among the homeless), on the other.

**Seniors**

The mean age of HIV/AIDS at first diagnosis has been rising over time. Now, individuals diagnosed with the disease over the age of 50 comprise 11-14 % of the cases in different regions in US. Persons over the age of fifty account for nearly 14 percent of recently reported AIDS cases in the District. The epidemic is growing among persons in this age group. Among males, the risk category MSM accounts for 38 percent of the cases and IDU accounts for 33 percent of the cases. Among females, heterosexual contact accounts for 44 percent of the cases and IDU for 34 percent of the cases. The increased survival of HIV infected patients, the late recognition of those with delayed or missed diagnosis, and rapid progression to AIDS among this group is likely to contribute to a future expected rise in the mean age of AIDS infected individuals. Given the general increase in health disorders associated with age and the risk of HIV associated illnesses in this aging subgroup, providing housing and health care poses special challenges.

**Hispanics**

According to the CDC, the HIV/AIDS epidemic is a serious threat to the Hispanic community. In addition to being a population seriously affected by HIV, Hispanics continue to face challenges in accessing health care, prevention services, and treatment. Although Hispanics make up only about 14% of the population of the United States, they account for 18% of all diagnosed AIDS cases. Of the rates of AIDS diagnoses for all racial and ethnic groups, the second highest was the rate for Hispanics. The highest rate was that for African Americans (76.4 cases per 100,000 people), followed by the rates for Hispanics (26.0/100,000). The 76,052 Hispanics living with AIDS accounted for 20% of all people in the United States living with AIDS.

In the District, the problem is a growing one. Right now Hispanics account for only 4 percent of AIDS cases. But this sub group faces special challenges due often to their immigration status apart from cultural and language barriers. Hispanics are among the poorest, and they do not access the health care system due to fear of being deported, language barrier, cultural factors, and lack of knowledge and information of available services and/or where and how to access them.

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Transgender Individuals

The epidemiologic information regarding transgender individuals living with HIV/AIDS is not collected and therefore not available. However, the Washington, D.C. Transgender Needs Assessment Survey\textsuperscript{102} revealed the following:

- 94 percent of the surveyed population (263) were people of color – 70 percent blacks and 22 percent Latinos.
- 59 percent are employed in paid positions; and 31 percent report annual incomes under $10,000; and 28 percent have no source of income;
- 47 percent have no health insurance;
- 25 percent of the respondents reported being HIV positive;
- 43 percent have been victims of crime and violence, with 75 percent of these attributing it to their sexuality or sexual orientation;
- About 20 percent of the respondents were homeless; the barriers to safe housing were reported to be economic situation (38%), insensitivity or hostility to transgendered people (29%), and lack of employment (23%).

The ‘unconnected’

A study by the Columbia University defined the unconnected as not only those who are currently not receiving HIV-related services, but also those who are marginal to the system – having no regular source of medical care, and those not receiving case management services even though they may have received some sporadic or urgent care.\textsuperscript{103} Such individuals are generally hard to reach, often either homeless or living in unstable living arrangements.

A second study conducted by Columbia University identified certain characteristics of the unconnected: majority were extremely poor, with a median household income of $6,875; many had unstable living arrangements and lived in hotels or on the streets; they were more likely than the connected to be drug users and in earlier stages of HIV infection; they were more likely to engage in risky sexual behaviors; and, they were more likely to have serious mental problems. The study concluded that it was hard to reach the currently unconnected because of client characteristics and barriers such as homelessness, drug addiction and mental illness.\textsuperscript{104} The report recommends that it is important for agencies to operate mobile clinic operations that seek out clients, provide clients with a safe place to live, sustain the relationship, and provide culturally competent health care services.

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Goal C

Ensure equitable access by all PLWHA to HIV/AIDS housing and other services.

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<th>Strategy</th>
<th>Activities</th>
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| C1: Provide targeted service to the marginalized subpopulations of PLWHA - women, youth, seniors, Hispanics, PLWHA in custodial settings and those released from prisons, transgenders, and the "unconnected." | 1. Identify vulnerable, marginalized and other potentially underserved populations in the District.  
2. Develop targeted policies and outreach programs for each of these groups.  
3. Prioritize these groups for health care and housing needs and help them overcome barriers to accessing care.  
4. Provide group-specific health communication.  
5. Use monitoring and evaluation mechanism to ensure that HIV/AIDS programs are producing the equitable results.  
6. Create opportunities for public dialogue on equitable access to HIV treatment and care. |

Goal D: Promote social mobilization.

Objective: Involve PLWHA and the larger community in the decision making process.

Strategy D1: Empower communities through promoting community-based participatory research, program design, implementation and evaluation.

Social mobilization is an approach and a tool that enables people to organize for collective action by pooling resources and building solidarity required to resolve common problems and work towards community advancement. It is a process that empowers women and men to organize their own communities, which in turn, enables them to initiate and control their own personal and communal development, as opposed to mere participation in an initiative designed by the government or an external organization.

Social Mobilization, as defined by UNICEF, is “a broad scale movement to engage people's participation in achieving a specific development goal through self-reliant efforts.” It involves all relevant segments of society: decision and policy makers, opinion leaders, bureaucrats and technocrats, professional groups, religious associations, commerce and industry, communities and individuals. It is a planned, yet, decentralized process that seeks to facilitate change for development through a range of players engaged in interrelated and complementary efforts. It takes into account the felt needs of the people, embraces the critical principle of community involvement, and seeks to empower individuals and groups for action.
The concept of social mobilization emerged from the recognition that a genuine participatory approach to program design and implementation is essential for its success and sustainability. Community participation in health interventions is increasingly recognized by organizations and governments as essential for improving responsiveness of policies and programs to the needs of beneficiaries and ensuring transparency and accountability in policy making and implementation processes. Genuine participation of communities and beneficiaries, however, goes beyond dialogue with or contracting a few community-based organizations. It must engage all stakeholders (women and men, in their various capacities, socio-economic status, affiliations and locations) and encourage active participation in making decisions that affect their lives. Engaging people requires efforts and mechanisms that can empower all, but most especially the disadvantaged members of society, to participate effectively in health related programs and processes.

“A review of successful and unsuccessful interventions reveals that communities must be involved as partners in the design, implementation, and evaluation of interventions. The best intervention results have been achieved when people who benefit from interventions work closely with researchers and public health practitioners. This phenomenon emphasizes the fact that those in the health community have ‘messages’, while individuals in target communities have ‘lives.’ A partnership between these two groups offers the best chance to bridge this divide.” 105

This strategy recognizes the importance of the participation of PLWHA in policy and program development, implementation, monitoring and evaluation while also recognizing the difficulty of fully engaging this population and subpopulations. Participation of the PLWHA is necessary for the effectiveness of responses, because it ensures that policies and programs are informed by the experiences of PLWHA, are responsive to their needs, and take adequate account of the full range of community effects on policy and program directions. To ensure community engagement in the housing strategy, PLWHA must be placed at the center of the programs and be supported through training and financial incentives to provide a leading role that guides and supports all government efforts. This strategy also recognizes that sustaining the involvement of PLWHA requires ongoing support to faith- and community-based organizations that represent PLWHA.

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<th>Goal D</th>
<th>Promote social mobilization</th>
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<tr>
<td><strong>Strategy</strong></td>
<td><strong>Activities</strong></td>
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<tr>
<td>D1: Empower community members through participatory research, program design, implementation and evaluation.</td>
<td>1. Identify community resources (community-based and faith-based organizations, community leaders and activists, researchers, health care personnel, and a cross section of PLWHA that includes the marginalized and other</td>
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potentially underserved populations in the communities) for participation in decision making processes.
2. Build a broad-based consortium that is diverse in composition out of the community-based resources identified earlier.
3. Empower consortium members by providing necessary training to the consortium members (as needed) on various aspects of program design, implementation and evaluation.
4. Promote community participation by supporting the consortium in designing, implementing and evaluating HIV/AIDS interventions.
5. Train consortium members to be effective peer educators.
6. Organize interactive awareness raising activities such as neighborhood meetings and rallies.

Goal E: Increase the awareness and visibility of HAA policies and programs through effective communication initiatives.

Objective 1: Increase the number of HOPWA funded housing and other service providers in the District.
Objective 2: Increase the number of PLWHA who utilize these services.

Strategy E1: Develop and implement a comprehensive communications program to reach a wide section of the community.

The programs administered by HAA and its range of activities need to be marketed effectively to the public through a process that has come to be known as ‘social marketing’. Social marketing is a practice that is widely adopted in the health sector for the communicating health-related information to the public using a variety of media outlets. Social marketing is similar to commercial marketing in that a range of commercial media are used for marketing purposes – to sells ideas, concepts and services. However, unlike commercial marketing, the purpose of which is sell products and services, the emphasis on social marketing is to change behaviors. The objectives of HIV/AIDS related social marketing are:

• Increase knowledge: The message should ensure that people have the basic facts in a language, visual medium or other media that they can understand and relate to. Effective social marketing message should motivate PLWHA to change their behaviors in positive ways.

• Stimulate community dialogue: Effective social marketing should encourage community discussions on the underlying factors that contribute to the epidemic, such as risk behaviors, risk settings and the environments that create these conditions. It should create a demand for information and services, and should spur action for reducing risk, vulnerability and stigma.

• Reduce stigma and discrimination: Communication on HIV/AIDS should address stigma and discrimination and attempt to influence social responses to them.

• Promote services for prevention care and support: Social marketing can promote messages that address several issues and services such as sexually transmitted diseases, counseling and testing services, mother-to-child transmission, support groups for people living with HIV/AIDS, clinical care for opportunistic infections, and other social and economic support that are available to PLWHA.

Mass media are undoubtedly the most important “vehicles” for creating awareness of social products as well as for distributing non-tangible products such as services. In urban areas, depending on the target group, television, cinema, and radio (with due attention to the right broadcasting time) as well as magazines, newspapers, posters, and other print media can be effective.

As a rule, the communication channels selected should be ones the target audience comes into contact with on a regular basis as well as perceives as being credible, since familiarity with a medium and with the performers makes it easier to get the message accepted. Projects that use media with entertainment value (movies, soap operas, radio plays, music, theatre, comics, and so on) are particularly successful.

However, since the impact of mass media is short lived, the message has to be periodically repeated to ensure its penetration of public consciousness. Posters or spots become monotonous, and the target groups may no longer even notice the message. It is therefore essential to change the “advertising” campaign from time to time to achieve the desired effect.

It is essential that the target groups should feel they are being personally addressed and taken seriously, with due respect to their human dignity and their private sphere. The way information is imparted must correspond to a target group's special needs and preferences as well as to the “product.”
**Strategy E2: Market HOPWA program to a broader cross section of community-based organizations.**

The network of service delivery agencies in the District that receive HOPWA funds through HAA numbers only about twenty. A clear strategy needs to be developed for marketing the HOPWA program to the numerous service providers in the District who are not availing of HOPWA funds at present. The lack of fuller utilization of HOPWA funds by a wider cross section of community and faith-based organizations in the District results in deceased service availability to PLWHAs. There is a need to attract more of these organizations through formal presentations, seminars, workshops, program literature, and regular one-on-one consultations.

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### Goal E

**Increase the awareness and visibility of HAA policies and programs.**

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<th>Strategy</th>
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| E1: Develop and implement a comprehensive media-communications program to reach a broad section of the community including community-based and faith-based organizations. | 1. Identify and appoint a media specialist from within or outside the HAA.  
2. Identify the target groups that are proposed to be reached through the media.  
3. Identify specific messages to each of the targeted groups.  
4. Match appropriate media with target groups.  
5. Build media partnerships.  
6. Increase funding for communication.  
7. Work with faith-based organizations which are often focal points for communities.  
8. Monitor and readjust communication strategies as times and needs change. |